DEPARTMENT OF HEALTH AND SOCIAL SECURITY

Report of the Working Party on Medical Administrators

Chairman: Dr. R. B. Hunter

LONDON
HER MAJESTY'S STATIONERY OFFICE
47p net

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SBN 11 320481 7

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Dr. J. T. Jones and Mr. H. G. Jones (both of the Department of Health and Social Security) attended many meetings as observers.

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PREFATORY NOTE

The Working Party met thirty-seven times between April 1970 and March 1972. It received written evidence from sixty-nine individuals and organisations, and heard oral evidence from individuals and from representatives of organisations on eleven occasions (see Appendix F).

FOREWORD

The aim of the National Health Service is to provide a comprehensive system of health care for the people of this country. Experience has shown that such an all-embracing objective cannot be achieved without considerable and steadily increasing expenditure. In 1949/50 the National Health Service in England and Wales cost £388 million; in 1970/71 it cost £2038 million. In 1971 the number of people working in the NHS was over 900,000, making the service one of the largest employers in the world. Yet all those concerned with the management of the service are keenly conscious of major deficiencies and of gross disparities in the availability and quality of services. Some still think that the solution to these deficiencies is simply to increase the amount of money the nation spends on health. More money, better buildings and more trained staff are undoubtedly needed, but it is equally important to ensure the effective utilisation of the resources that are already available. Considered decisions about priorities and objectives and continuing study of the performance of existing services are essential. New patterns of care must be developed to meet changing needs and to derive benefit from advances in treatment and prevention. At present opportunities for effective resource planning and management are limited by the administrative divisions between existing health services. The re-organisation of these services in 1974 will remove such obstacles, and it will be the responsibility of all those concerned in management within the unified service to seize the opportunities which will thus be presented.

There is still wide scope for the prevention of disease, and a proper balance must be maintained between the resources devoted to this and the services providing care and cure. In the case of the latter, clinical demand largely determines the employment of available health resources, and the final demand on resources is the aggregated result of innumerable clinical decisions. Doctors must accordingly be actively involved in planning and running health services. Their knowledge and judgment must play a substantial part in determining policy, and they must accept a major share of responsibility for ensuring the effective use of resources.

Our terms of reference clearly assume that there will continue to be a need for some doctors to work full-time in health service administration, and that these doctors should form a group distinct from those engaged primarily in clinical practice. We have examined this assumption carefully and fully accept it. We identify in our report the role and functions of these doctors, with particular reference to the re-organised service. We believe that in future these doctors must receive appropriate postgraduate training and experience in order that they may become specialists in community medicine. Such specialists are concerned with the application of medicine to whole populations or to defined groups and hence with the ascertainment of health needs and how professional services can best be organised to meet them. They combine a broad knowledge of medicine and the organisation of health services with specialist training in investigative and analytical skills. They must also, where necessary, accept responsibility for communication with the general public. In our view, if health services are to be effectively planned and run, specialists in community medicine will be essential at every level in the service. Their role will not simply be to undertake duties which at

present fall to the medical officer of health and medical administrators in the hospital service. The need exists for community medicine specialists to broaden and develop this work and carry out essentially new responsibilities in relation to planning and management in an integrated service.

Their work will be essentially complementary to that of non-medical administrators on the one hand and clinicians on the other. By collecting, analysing and presenting information on health needs and use of resources, they will provide the basis for rational planning and decision making. They will form an essential link between those who provide clinical services and non-medical administrators. In the early years of the re-organised service they will have a vital part to play in securing the functional integration of services and they will be ideally placed to help doctors to appreciate how they can work more effectively with each other and with nurses and other health service staff and to promote administrative arrangements to assist this. They will also be concerned to promote the co-ordination of health and relevant local government services.

To undertake this key role doctors at present working as medical administrators will need retraining along the lines we have already recommended in our interim report. In our view, the job of a specialist in community medicine in an integrated service offers so much scope, and is of such fundamental importance to the future of the service, that it should attract some of the best medical graduates, and their opportunities for training and their career prospects must therefore be as good as in other specialties. They will be undertaking one of the most responsible tasks in the whole service. To a considerable extent the success or failure of the integration of the health service will depend upon their quality. Because of this we hope that this report will be widely read by medical students and young doctors and will help them to appreciate the developing opportunities open to them in this specialty.

We do not under-estimate the problems community medicine specialists will face in undertaking the essential tasks we see for them. For example, effective information systems will be a basic tool of the community medicine specialist, and to establish them will require an immense collaborative effort involving many other professional staff, within and outside the health service. Similarly, in seeking to further functional integration, community medicine specialists will find it necessary to promote changes in attitude as well as in organisation. These ends will not be achieved overnight; but from the evidence we have received, we believe that the will exists within the profession to meet this challenge.

R B HUNTER
Chairman

CHAPTER I
INTRODUCTION

1. We were set up as a working party "to review the functions of medical administrators in the health services and to make recommendations regarding the provision required for their training".* Our terms of reference implicitly assume that medical administrators are a clearly identifiable group distinct from other doctors and from other health service administrators. They also assume that medical administrators have particular training needs which require separate consideration from those of other doctors.

2. We have necessarily had cause to look at these assumptions and to consider various points which underly them. For example, what are the hallmarks of the medical administrator? What is the expertise which he can provide which is better provided by him rather than by other administrators? Does this expertise stem from his being a doctor with a wide range of general clinical experience, or a doctor expert within the specialty of community medicine? These questions have led us to consider the whole concept of the "community physician", to whose messianic coming so many writings give testimony though not all with one voice. We do not, however, claim to write on tablets of stone.

3. In recent years, there has been a growing recognition amongst clinicians generally that to be effective practitioners they must be concerned with the organisation of their medical work and the interrelationship between it and the work of other health professions. The doctor, whether in hospital or in general practice, needs to call on a wide range of resources in terms of personnel and facilities, and, in turn, his services are required to complement the work of others. In hospitals an attempt is being made by clinicians to consider collectively the organisation and management of their work through the "Cogwheel" type of structure. In group practice and health centres general practitioners are also coming to see that good management is an integral part of their work. The increasing complexity of the service is therefore compelling doctors to act as managers in relation to their own clinical work. Clinicians generally are also coming more and more to realise that their role should include not merely care in time of illness, but also prevention and after care. This concept of total care will be easier to realise within a unified service but will necessarily increase the need for clinicians to concern themselves in the organisation of health services. This is, in our view, both inevitable and desirable, and nothing we shall say in this report is intended to negate or diminish this essential aspect of clinicians' work. However, the main concern of these doctors is with clinical care, and for the purpose of our report we have regarded our terms of reference as referring solely to those doctors in the health service (and also, where appropriate, to those in the central Health Departments—see paragraph 11) who are wholly or substantially concerned in medical administrative work and who are not primarily

* The working party was set up in March 1970 by Mr. Richard Crossman, Secretary of State for Social Services in the previous Government, with the following terms of reference:

"to define the scope of the work of medical administrators at regional, area and district levels in a reorganised health service, and to indicate how training and retraining for such doctors could be provided".

In July 1970, the Secretary of State, Sir Keith Joseph, asked that the working party should continue its work with the more general remit cited above.

practitioners in clinical specialities. Such doctors are currently employed mainly by local authorities and regional hospital boards and in the central Health Departments. The numbers involved are set out in Appendix B.

4. The Todd report* included these doctors among those who practised the specialty of community medicine, and the newly formed Faculty of Community Medicine has subscribed to this view. Todd defined community medicine as being concerned "not with the treatment of individual patients but with the broad questions of health and disease in, for example, particular geographical and occupational sections of the community, and in the community at large. It embraces many activities and interests, and includes doctors employed in different spheres, partly because the health services have developed in this country under different authorities. It makes use of a variety of techniques and procedures which are not necessarily exclusive to it. Nevertheless the functions of all doctors working in this field are closely related; there are no intrinsic differences in their requirements for basic training or in the techniques they employ". We accept the view that the different fields in which doctors in community medicine practise are sufficiently closely related to require a common basic training and experience, and that these doctors form a distinct group analogous to that formed by, say, surgeons.

5. We are aware that there have been different views expressed as to whether specialists in community medicine should form a part of the health services administration or whether they should be regarded as practising their specialty in effect as a service to, rather than as a part of, management. To be an administrator within the health services, whether medically qualified or not, seems to us to imply clearly that the person concerned accepts some kind of management responsibilities, either as an individual or collectively as a member of a team, for all or some of the services provided. He is essentially a part of the administrative framework necessary within an organised service, and the exercise of administrative skills must form a significant part of his work. For this reason a doctor who aspires to a full time post in medical administration needs, in our view, to obtain as part of his training some knowledge of management and administrative skills. It would be possible to envisage a health service administration which looked to specialists in community medicine for advice in matters relating, for example, to the epidemiological assessment of need and qualitative assessment of health care services and where the specialists giving such advice would have management responsibilities no different from those exercised by clinicians. We would accept that within a unified health service there will be some doctors, whose specialty is community medicine, who will have a primarily advisory role in relation to the administration and to clinicians, and that they will be regarded as advisory specialists rather than medical administrators; some of these doctors may also hold university appointments. However, we are convinced that there should be a substantial number of doctors at all levels within a unified service who are also engaged in administrative work as described above, and that the prime source of recruitment of these doctors should be from those trained in community medicine.

6. Our reasons for this belief are as follows. First, we think it is necessary to

* Report of the Royal Commission on Medical Education 1965–68 (Cmnd 3569): HMSO, 1968.

provide within the administration at all levels channels of communication between the authority and clinicians which command the full confidence of the latter. We doubt if this is possible unless there are doctors engaged full time in the administration. Second, we believe that the work of the community medicine specialists, as we make clear in this report, will be so closely concerned with illuminating the issues which will confront health service authorities in carrying out their responsibilities that it will be essential that their expertise should be fully utilised. We think this is much more likely to be achieved if they have accepted places within the administration rather than purely advisory roles. We would agree, therefore, with the conclusions of the working party established by the Nuffield Provincial Hospitals Trust that medical administrators "must work on two professional levels, as specialists in the medicine of the group and in relation to the community at large, and also as administrators".* In addition, we feel strongly that if doctors are to play a leading part in health service administration it is vital that young doctors should see an attractive and challenging career in this field. We do not believe that young doctors of the calibre needed will be attracted into community medicine in the numbers required unless they are assured of a future role in management; nor do we believe that there is any hope of meeting satisfactorily the essential need for doctors in administration in any other way.

7. Because of our belief that training in community medicine will be an essential part of the background of those who choose a career in medical administration, and because the exercise of their skills as specialists in community medicine seems to us to be the most distinctive contribution these doctors will make to the administration of the health services, we have chosen in our report to refer as a general rule to the role of the community medicine specialist within the unified health service rather than to use the term "medical administrator". As we see it, specialists in community medicine will be engaged in a wide range of activities, in which the elements of administrative as distinct from more medically orientated work will vary according to the responsibilities of the post, and we think the description "specialist in community medicine" as a generic term for the doctors concerned is more apt than "medical administrator", which we think gives a too restricted impression of the work involved.

8. While it is not our intention to promote the claims of community medicine specialists to be chief executives of the new health service authorities (should such appointments be made), or to be the sole source of their medical advice, it is our belief that they, more so perhaps than any other staff within the health service, will best be able, by virtue of their training and experience, to exploit the potential benefits of unification. They will carry also a heavy responsibility for achieving this. As background to our examination of the task of community medicine specialists at different levels within the health services, we examine in Chapter II the contribution community medicine can make generally to the organisation and management of a unified health service.

9. We have not found it necessary to annex a glossary of terms to our report but it will be as well at this stage to clarify how we use the term "community".

* Report of the working party on the training of doctors for the administration of hospital and public health services, paragraph 14, contained in "Vocational training in medicine", Nuffield Provincial Hospitals Trust, 1967.

We are aware of the common description of services outside the hospital—whether institutional or domiciliary—as "community services". We think that the integration of the health services, if no other reason, will make this term inappropriate. In order to be consistent with our use of the term "community medicine" we use "community" to embrace the whole population of a given area. We use the term "primary care" to describe the services provided by family doctors and other health service staff not working within what are currently recognised as hospital specialist services. This does not imply that general practice is not regarded as a specialty—family doctors are of course specialists in primary care. We also refer extensively to "clinicians" in our report. We would regard a doctor as engaged in clinical work when he has direct care of individuals or when his work is specifically related to the diagnosis and treatment of individual patients.

10. We have not included in the main body of the report any account of the work at present undertaken by medical administrators within the present health services organisation, as we see it as our task essentially to look to the future. We do, however, give a brief description of this in Appendix C, and we refer to the present arrangements for the training of medical administrators in Chapter VII.

11. Our terms of reference restrict us to consideration of the functions of medical administrators within the health services. We have not given detailed examination to the functions of doctors working in the Department of Health and Social Security or the Welsh Office because, although many of them are intimately concerned with planning and supervision of health services and with advising and liaising with health service staff, they are civil servants and work outside the health services. Further, we have been informed that the organisation of the Department of Health and Social Security is currently being reviewed. However, we fully endorse the views expressed in the Consultative Document* that the staff who are concerned with the central administration of the National Health Service needs to include people with direct experience in the field. We are particularly concerned that community medicine specialists employed by the health service authorities should have opportunities to gain experience in the central Health Departments and that, in turn, staff in these Departments should have opportunities for working with health service authorities. We discuss some implications of this in our chapter on training and career structure. A brief account of the work of doctors on the health side of the Department of Health and Social Security and the Welsh Office is included in Appendix C.

CHAPTER II

COMMUNITY MEDICINE IN A UNIFIED SERVICE

12. The major objectives in re-organising the administrative structure of the National Health Service might be briefly summarised as follows:—

i To unite the services so that at each level all are administered by a single authority and so that services which have been separated in the past can be integrated.

* National Health Service Reorganisation—Consultative Document: DHSS, 1971.

ii To develop higher standards in the promotion of health and in personal patient care.

iii To define needs locally, regionally and nationally; to set clear objectives and standards for health services and to measure performance against them, relating achievement to the use of resources.

iv To provide a framework which makes possible closer working links between the health services and the related services provided by local government.

13. Administrative re-organisation can only facilitate these developments; success or failure will depend on how the new authorities and their staff tackle the task of integration. Whilst unification will solve many existing problems, fresh problems, as well as new opportunities, are bound to arise, particularly in the period when new working relationships are being formed.

14. The National Health Service is unique in its scale and in the wide range of skills that it employs. No single group of staff can have more than a part of the knowledge and expertise required to make integration a success. Whatever responsibilities are formally given to different staff of the new authorities, the co-operative effort of all will be essential. We believe, however, that community medicine specialists will have a key role to play at every level, because the aims of community medicine are so closely related to the objectives of a unified service.

15. The question of priorities is at the heart of health services administration at every level. The unified health service will make it possible for those running the service to look at deployment of health resources as a whole, and for the first time they will be in a position to try to achieve the best balance of services. The relative strengths of primary and specialist care, choice of priority between new and expensive forms of treatment and less spectacular procedures, the balance which should be struck between preventive medicine and the therapeutic services, between medicine which cures and that which alleviates suffering—these are just some examples of the issues which will concern the new authorities. Within a tripartite service many of these problems are academic as no single authority has the responsibility to decide or the power to act on its decisions. The community medicine specialist is not uniquely endowed to answer such questions, but because of his specialist training and experience he will be qualified to play a major part in the assessment of need, the analysis of existing services and the resolution of problems of choice.

16. Community medicine specialists will also be involved in promoting improvements in health services, particularly through better co-ordination, and in developing new services. At district level they will be actively encouraging co-ordinated working through their contacts with clinicians and other health service staff. At area, regional, and national levels, they will have a continuing concern with the organisation of health care and with promotion and co-ordination of research and development in this field.

17. The concern of community medicine with the general health of the population extends more widely than the direct responsibilities of the new health service authorities. In considering the organisation of health care, community medicine specialists must also have regard to the services provided by central and

local government agencies and voluntary organisations, and to the need for full co-operation with these bodies.

18. Bringing together practitioners of community medicine into the same service will remove the artificial and restrictive division which has separated them and will facilitate the development of a coherent approach to the promotion of health and planning of health services. But the new division of functions between local government and the health service will loosen the valuable ties which have existed within local government between those personal health services which until re-organisation will remain a local government responsibility and the social, education, housing, and environmental health services which it will retain. Community medicine specialists will have a leading and positive part to play in creating close and constructive relationships with the new local government authorities in all these matters. We would not wish to emphasise one if it were in any way to diminish the importance we attach to the others, but we would record our conviction that it is essential that the new local government authorities responsible for environmental health matters should obtain the medical advice they need from the community medicine specialists within the National Health Service, and that this advice should be sought not only on those specific matters in public health on which medical guidance and leadership has always been regarded as necessary, but across the spectrum of environmental planning as a whole. The role of the medical expert in public health matters has changed markedly over the years but the need for there to be medical expertise remains as strong as ever and community medicine specialists must be ready to provide it, both to meet the new challenges to health thrown up by a rapidly changing society and to ensure that in planning the physical development of the environment, full account is taken of its potential impact on the health and well-being of the community.

19. We are aware of problems of recruitment of doctors to posts with local authorities, regional hospital boards and the central Health Departments which we would regard as within the field of community medicine. These problems have stemmed partly from the divided structure of the health service with the limitations this has necessarily placed on the scope of the work, partly on the lack of recognition in undergraduate and postgraduate teaching of the role of community medicine, and partly from the lack of career opportunities comparable to those in clinical medicine. We believe that doctors in community medicine can and should be able to obtain the same standing within the profession as their colleagues in clinical practice and should have comparable career prospects. The advent of a unified health service presents an opportunity to bring this about which must not be ignored. Our report will indicate what these opportunities are and will suggest what the training and career structure requirements may be. It will also be necessary to provide extra resources for these purposes, and it is essential that these be made available.

20. Some doctors have reservations about the whole idea of "management" of the health services, particularly at a local level; these reservations frequently arise from a concern lest management will interfere with clinical autonomy, a risk they think will be greater if doctors other than clinicians are engaged in management. We believe these views are mistaken and arise from confusion about the connections and differences between patient care on the one hand and

the organisation of services on the other. There are, as we see it, two main aspects to this matter:—

i The doctor–patient relationship, in which the clinician cares personally for an individual to the best of his ability. We accept entirely the duty and right of clinicians to exercise their own clinical diagnostic and therapeutic judgment without individual judgments being subject to assessment by a managerial superior whether or not medically qualified.

ii The doctor's use of the resources of health services. Here the clinician is inevitably faced with constraints of many kinds—changing priorities in public policies (for example, on the care of the mentally ill), public opinion, and the claims of fellow clinicians. At a local level, the decisions of the area authority or district management on such matters as health centre development, the clearing of waiting lists, the redistribution of operating sessions or emergency admissions between hospitals, or the redistribution of consultative out-patient or nursing services between hospitals and general practice, will all act as external constraints on the freedom of action of clinicians, though not their freedom of judgment.

21. Clinicians will wish and need to be involved in these decisions. The specialist in community medicine must also be involved because his concern is essentially with the health of the community generally—the prevalence of ill-health and the need for health services—and with the investigation and evaluation of services provided. Clinicians and community medicine specialists in future are likely to meet more frequently at a local level, for example, in considering the outcome of particular health services in terms of benefits to the local population and in relation to the expenditure of the limited resources of the service. It will be their joint concern to see that the right decisions are reached by the appropriate authorities after an adequate presentation of all relevant available evidence.

22. The type of problem on which a collective approach involving clinicians, community medicine specialists and others will be necessary can be illustrated by the example of the patient with a heart attack. Opinion on whether he should be kept at home or admitted to hospital has shifted from time to time. This kind of clinical problem is the responsibility of the doctors (the general practitioner and the consultant who may be called in), the patient, and his family. But what hospital facilities the community can provide is a question of priorities and resource allocation—across the whole service—which the appropriate health authority, after full consideration, will have to decide and implement. There is no chance whatever of being able to do everything that everybody would like, such as providing modern "coronary care" at hospitals that are within short and easy access of everyone. The unification of the health services will make possible for the first time the necessary comprehensive community examination of problems which must precede diagnosis and decisions on appropriate action. The knowledge and expertise of the community medicine specialist will be an essential contribution to the processes of examination, diagnosis and decision.

23. Or, again, the local committee of doctors, in the light of the analyses presented to it by the community medicine specialist, may recommend that the identification and control of high blood pressure should be the next step in preventive medicine for the local population. Together with the administrators, they

would be concerned with budgeting such a programme, in terms of extra professional time, public education campaigns, possible methods of identifying "silent cases", and so on; it would then be for the area authority to decide how far it could support the proposal in comparison with other desirable advances—including the claims of numerous other people needing help and not receiving it who could be identified by the application of modern epidemiological techniques to clinical practice (for example, drug addicts and alcoholics, or vulnerable young children and old people).

24. In short, we believe that clinicians will have much to gain from a specialist in community medicine, expert on local needs and how far services meet them, assisting those who participate in the service to work more effectively, and advising on the health of the whole of the local population. We believe it would be against the interests of the profession as a whole and of the development of improved management within the health services if this is not generally recognised and accepted by clinicians.

CHAPTER III

THE COMMUNITY MEDICINE SPECIALIST AT A REGIONAL LEVEL

25. The Consultative Document stated that "the regional health authorities will be responsible for the general planning of the NHS (including the specialties and, in consultation with the Universities, the service facilities to be provided in support of medical teaching and research) in each region; for allocating resources to the area health authorities; and for co-ordinating their activities and monitoring their performance (including the effectiveness of their links with the matching local authorities) to ensure that national and regional objectives are achieved and that the desired standard of service is provided. In addition, the regional authorities will themselves provide some services and will be the building authorities for all major projects". The Consultative Document also stated that there will be either fourteen or fifteen regional authorities in England. No regional health authority is envisaged for Wales. The number of area health authorities per region will vary quite substantially, probably from three to ten or eleven with most regions containing between five and seven authorities.

26. The detailed management arrangements for the new authorities are currently under consideration by an expert management study group with members appointed by the Secretary of State, so we do not know the precise structure within which the community medicine specialist may work at regional level. However, we are sure that there will be a need for a chief administrative medical officer (CAMO) at regional level, supported by a team of other administrative medical officers. We outline below what we see as the main functions of these staff.

CENTRAL PLANNING AND DETERMINATION OF OBJECTIVES AND POLICIES

27. The chief administrative medical officer will be a member of the group of administrative and professional chief officers bearing the main responsibility for

advising the regional authority on the overall development of services, including capital programmes. He or a member of his staff will be involved in the necessary consultations with the central Department about the setting of national objectives, and will participate with his professional and administrative colleagues in defining objectives at regional level. He will be similarly concerned at both levels in the translation of objectives into workable policies for their achievement bearing in mind the likely availability of resources, and for this purpose, will have executive responsibilities delegated to him by the regional authority.

28. The CAMO and his staff will bring to bear their own knowledge and skills in this work. Part of this skill will be in the collection and co-ordination of the expert views of doctors within the region, particularly through the authority's medical advisory bodies, whose effective functioning will depend very largely on the services provided for it by the chief administrative medical officer's staff.

29. Under the proposed local government re-organisation, there will be no parallel regional authority with responsibilities for related local government functions—social services, education, environmental hygiene and housing services. Collaboration with local government authorities in the planning and provision of services will be a prime responsibility of the area health authorities, and we would not wish to see the regional health authority taking it over from them or to see a situation in which individual local government authorities dealt separately with area and regional health authorities, perhaps over the same issues. However, we also recognise that in discharging its strategic planning functions, the regional authority will wish to consult with local government authorities, and to this end we think the regional CAMO, in conjunction with area chief administrative medical officers, will need from time to time to consult on a collective basis with the chief officers of the local authorities, and in particular the directors of social services. In addition, he may need to be present or be represented in discussions between individual area health authorities and local government authorities where substantial planning issues are involved.

30. A central part of any overall plan for the development of health services will be planning the development of medical specialties and medical manpower policies within the region, including general practice. We assume that it will be a responsibility of the regional authority to control overall medical staffing establishments* within the region, regardless of whether or not the doctors concerned are in contract with the regional authority, and that this control will be exercised within the framework of national medical manpower policy. Forward planning of medical staffing and the related subject of development of medical specialties will be a particular concern of the CAMO and his staff. In this they will need to work in close collaboration with appropriate medical staffing advisory machinery and with area health authorities. Medical staffing must be planned in an integrated way, both with nursing and allied services and with the scientific and technical services; medical participation in their planning will therefore be essential.

CO-ORDINATION AND MONITORING OF HEALTH CARE SERVICES

31. The chief administrative medical officer and his staff will be concerned in particular with co-ordinating and monitoring the medical services provided

* We assume the Medical Practices Committee will continue to exercise its present control of numbers of doctors in general practice in any given area.

by the area health authorities, including their links with related local government services.

32. Co-ordination of services between areas will be particularly necessary for hospital services, especially those which must be based on a population larger than that of one area. The regional authority through its medical staff will have a responsibility for ensuring appropriate location and development of these "regional" specialties, although we consider these specialties should be provided and run by the areas and not the region. The region will also be responsible for ensuring co-ordination of specialist services in general. We envisage that in achieving this, much will depend on building up relations between the administrative medical staff of the region and their colleagues at area level.

33. Detailed monitoring of services for which the area is responsible must be primarily a matter for the area authority, but we envisage each region monitoring area services by obtaining regular and defined information on the areas' performance. From time to time the region may also wish to arrange ad hoc studies for particular purposes. All these arrangements will need to be planned in close collaboration with the area medical staff and representatives of the clinicians concerned.

RESOURCE ALLOCATION

34. The chief administrative medical officer and his staff will be involved with other chief officers in discussions with both the central Department and the areas about the allocation of resources to region and area. They will also be concerned with the medical manpower available to the region and its distribution to area health authorities.

OTHER FUNCTIONS

35. We see certain other specialist functions for the CAMO and his staff. These include:—

i Building up and maintaining health information services for the region.
ii Postgraduate medical education.
iii Provision of medical expertise in the handling of building projects.
iv Encouraging and promoting clinical research and research into the operation of the medical services.
v Providing or arranging for the provision of specialist advice.

INFORMATION SERVICES

36. Both regional and area authorities will need to have comprehensive information systems, and to have access to adequate data processing facilities in terms of computer and allied installations. Bringing together the existing information systems, the current growth of technical capabilities in the field of information engineering and the larger needs of a more comprehensive administrative system, will create a demand both for capital investment and skilled staff. The two main areas of work can be identified as systems engineering and information services. The former is concerned with the handling of health services informa-

tion as a "material", with emphasis on the mechanics of its collection, storage, retrieval, and distribution, rather than its meaning or the use to which it is put. Information services are concerned with the meaning of information and with "intelligence" relevant to decision making either clinical or administrative. The chief concern of the community medicine specialist in this field will be with the development of health information services for management purposes.

37. At this stage it is not possible to define in detail the scope and content of a regional information system, as we do not know the administrative powers which will be vested in the region nor the form regional supervision of area health authorities will take. The decision making requirements of the administrative system must be determined before appropriate information systems are designed to meet them.

38. It is clear, however, that for the effective discharge of its responsibility for planning and supervising comprehensive health services, a regional authority will need to have an overall view of the health and health care needs of the population it serves, and for this purpose will need a regular flow of health information relevant to the planning and evaluation of health services and the administrative decision making process generally, including, where relevant, the transmission and recording of information which is an integral part of operational activities. Given the scarcity of qualified staff, and the need to take advantage of economies of scale, we think that the major information services should be provided by regional information services units, and that such units should be established as a matter of high priority. Information on primary care services on a regional basis is at present lacking and this is a matter which will need early attention.

39. In the region there will need to be a senior medically qualified member of the CAMO's staff who will be expert in identifying the information requirements for health service evaluation, management and planning, and knowledgeable in the use of modern data processing facilities for these purposes. He will be a key member of the multi-professional team directing the information services unit and will bear particular responsibility for seeing health information requirements are met in full.

40. The level of expertise which will be necessary at regional level suggests that the regional staff should advise the areas on the development and application of health information systems to the areas. At area level, there will be a need for doctors with specialised knowledge of information needs and interpretation of data, but not the same degree of involvement with the design and operation of information systems.

41. The information needs of region and area will vary according to their respective responsibilities. There will be some matters on which both will need to be informed, and others where the primary or sole concern will lie with the area—for example, in matters relating to the detailed operation of health services where the management authority responsible will be the area rather than the region. If the region is to operate satisfactorily as the agent of the area in providing its data processing capability, there will have to be very close collaboration between the officers of the area and region, and area authorities will have to have an effective means of influencing the management of the regional unit.

42. We discuss health information requirements in more detail in Chapter IV (paragraphs 57–59).

POSTGRADUATE MEDICAL EDUCATION

43. Postgraduate medical education requires the involvement of the NHS authorities, the universities and royal colleges and similar bodies for its planning and organisation. For this purpose, regional postgraduate committees,* on which all three interests and that of the profession itself are represented, have been constituted in each of the present hospital regions. The chief officer or chairman of the committee is frequently the postgraduate dean. At a national level there is a Council for Postgraduate Medical Education. We think that, in a unified service, there will be an opportunity to strengthen current arrangements and for the regional health authorities to take overall responsibility for seeing that service authorities meet their obligations in this field. This involves seeing that doctors have the physical facilities they need for formal education and study at or near their place of work and that they have sufficient opportunity for study and professional leave. Service authorities must also work closely with the universities and professional bodies concerned to ensure that there are enough approved training posts (including pre-registration posts) in appropriate locations. This aspect of postgraduate education is closely linked to medical manpower planning.

44. Regional authorities cannot take sole responsibility for the discharge of these functions. Area health authorities will necessarily be involved in maintaining the standards of training posts and facilities such as libraries and postgraduate medical education centres. It is desirable that the chief administrative medical officer, or a member of his staff working in close collaboration with the postgraduate dean, should have an overall regional responsibility for coordinating this work, to provide a point of expert contact for doctors in the region and for educational bodies, and to maintain liaison with the regional postgraduate committee.

CAPITAL BUILDING

45. The Consultative Document envisages (paragraph 9) that the regional authorities will be the building authorities for all major projects. The regional "works" team of architects, quantity surveyors and engineers will need to have advice in planning building projects from medical and other sources. It will be the responsibility of the CAMO and his staff to provide, or arrange for the provision of, medical advice. This will include assessment of medical facilities to be provided at teaching centres in support of medical teaching and research.

RESEARCH AND DEVELOPMENT

46. We assume that the new regional health authorities will administer funds for locally organised research. In the medical field we see a role for the chief administrative medical officer or a member of his staff in helping to determine priorities and in promoting interest in research in the light of expert advice from specially constituted regional research committees.

* The main functions of regional postgraduate committees are to promote and keep under review postgraduate medical education and training in their regions; and to advise universities and hospital authorities on the necessary arrangements and facilities required.

47. A unified health service will provide new scope for research. There will be a need to promote not only clinical research, research to promote technological innovation, and research in collaboration with other disciplines (for example, nursing and para-medical services) but also research to assist the regional authority in its task of strategic thinking and forward planning. Research of this last kind will often need to be a team effort involving skills from many disciplines. These teams may be based on area or on region and may need to include experts from outside the health service. We do not wish to suggest a model arrangement but we are clear that the administrative medical staff at regional level should regard it as an important part of their functions to promote research into the provision of health services. There should be opportunity for collaboration with university departments of social medicine in this field.

SPECIALIST ADVICE

48. We envisage that in certain specialist fields the regional authority will need to see that advice is available to area authorities. Some of these fields will be non-medical—for instance they may be related to scientific and technical services or operational research. On the medical side there is a need for a small number of highly specialised community medicine specialists whose interests would lie in the field of the environment, taking that word in its broadest sense. In particular, inadequate attention and study have been given to the relationship between health on the one hand and town and country planning, building and building design on the other. Such writings as there are on these subjects have generally not been based on scientific studies, and there is a need to develop this aspect of community medicine and to build up a corpus of knowledge on which advice to local government and to health authorities can be based. This responsibility in health promotion will involve collaboration with the Department of the Environment as well as local authorities.

49. Similarly, contamination of the environment by modern industrial processes is presenting a wide range of problems, and we see a need to ensure that advice is readily available on toxicology. As field experience of the control of outbreaks of communicable disease is becoming scarcer, many areas will need to seek outside advice from people expert in the epidemiology and control of communicable disease. In some instances the advice required may fall within the range of expertise of the chief administrative medical officer or other community medicine specialists employed by the regional health authority. In others, reference to expert outside help may be necessary e.g. as at present provided by the Public Health Laboratory Service in the bacteriological field. The role of the CAMO will be to see that such sources of advice are available and can readily be tapped, particularly in times of emergency. United to these functions will be the development, in conjunction with the experts concerned, of regional plans for dealing with emergencies caused by natural or other disasters and by large scale outbreaks of communicable disease.

STAFFING REQUIREMENTS AT REGIONAL LEVEL

50. The new regional authorities will have much wider responsibilities than the existing regional hospital boards; on the other hand there will be area health

authorities operating below them and employing their own chief administrative medical officers and other specialists in community medicine. The regional health authorities will be concerned with the determination of strategy and regional policies rather than operational matters.

51. Staffing requirements of regional health authorities will vary according to size and geography and the number of area health authorities within each region. We do not think we can lay down a blueprint for the allocation of responsibilities of the CAMO's medical staff. Different approaches are possible. As a guiding rule we would like to see responsibilities allocated to staff in such a way as to ensure a comprehensive approach. A functional division of duties on the following lines might achieve this:—

i Planning and resource allocation.
ii Co-ordination and monitoring the operational performance of area health authorities.
iii Information and research.
iv Medical manpower policies.
v Postgraduate medical education.

However, any division of duties on the medical side must be related to the management structure of the whole regional health authority.

52. The need for a medical expert in information services in each region is most important, and health service authorities must be able to recruit to senior posts in this field doctors with suitable specialist experience who may not have had the usual training as specialists in community medicine.

CHAPTER IV

COMMUNITY MEDICINE SPECIALISTS IN AREA AUTHORITIES

53. The Consultative Document describes the new area health authorities as "the operational NHS authorities, with responsibility for planning, organising and administering comprehensive health services to meet the needs of their areas. Each area authority will also be responsible for the management of the integrated health services in the various parts of its area ('districts') served by separate district general hospitals and the community health services associated with them". The area authorities will inherit plant, equipment and patterns of service which are the legacy of a quarter of a century of a divided health service. In future it will for the first time be possible to plan and operate the health services of each area as a whole.

54. Area health authorities will differ considerably in size; we understand that it is likely that about a third of the areas in England and Wales will consist of only one health district, while over half will have two or three districts and a few will have four or five. The populations of areas will vary from 0·2 million to 1·5 million. It has been estimated that districts may have annual budgets of around £8 million on average, so that many areas will be responsible for spending £15–£25 million each year. Within a district there may well be up to 3,000

health staff, including up to 300 doctors and dentists. The services for which, under the terms of the Consultative Document, areas will be responsible are set out in Appendix D. In the new unified service, community medicine specialists will have a special role to play in securing the most effective use of the area authority's considerable resources of money and manpower in relation to the needs of the population, both in the determination of priorities and the best management of resources.

55. The functions of community medicine specialists will be the same in all areas, but because of differences in size and complexity of areas, there will be variations in the numbers in each area and in how they are deployed. We have had to consider the functions of community medicine specialists without knowing what may be the general management arrangements and responsibilities at area and district level, or the relationship between officers who may be appointed with district responsibilities and officers based at area. This has not affected our conclusions about functions, but it has made it more difficult for us to establish the relative status of staff at district and area level, and how community medicine specialists employed by the area should be deployed. We are, however, convinced that there should be a specialist in community medicine particularly concerned with each district-sized population.

FUNCTIONS OF THE COMMUNITY MEDICINE SPECIALIST

56. The functions we see for the community medicine specialist operating within an area or part of an area can be described under five main heads:

i Provision of health information.
ii Planning.
iii Management.
iv Advice and assistance to local authority departments—particularly social services and education—and to voluntary and other bodies, on the planning and management of their services.
v Provision of medical services required by local government authorities with responsibilities for environmental hygiene and communicable disease control.

HEALTH INFORMATION

57. The planning of health services depends upon the assessment of need, which must be based upon a systematic investigation and analysis of the total health situation of the community and also upon knowledge of the strengths and weaknesses of existing services. Management, in turn, cannot be effective without reliable information on the operation of services. Each area authority will, therefore, as a matter of priority, have to establish and maintain an area health information system covering all health needs and the operation of all relevant services. This will need to be done in collaboration with related local government services, particularly those provided by departments of social service, as effective co-ordination of health with the other social services depends upon the sharing of knowledge of the problems and capabilities of each service. The establishment of such an information system requires the epidemiological and evaluative skills of the community medicine specialist and, in turn,

will provide him with the essential equipment he needs to do his work. It will, however, require a considerable expenditure of time and resources, and will need the full co-operation of all concerned.

58. In the previous chapter, we recommended that each region should set up an information unit and that a medical specialist in the development and use of information systems should be a senior member of its staff. We also suggested that the regional unit should provide specialist services and advice to areas. At area level, a community medicine specialist will be needed to take special responsibility for health information within the area, although he may not need to specialise to the extent of his counterparts at regional level. He will need some non-medical supporting staff as well as assistance from professional colleagues. At the outset of the new service, there will be a considerable shortage of suitably experienced medical staff and increasing the numbers expert in this field should be a high priority.

59. At area level, it will be particularly important to have information about the following:

i The demographic character of the area.
ii Health needs as indicated, for example, by morbidity and mortality data.
iii Physical resources.
iv Manpower.
v Needs for services.
vi Demands made on services.
vii Performance—qualitative and quantitative.
viii The social services, the education services, housing, environmental hygiene and communicable disease (by arrangement with local authorities).
ix Voluntary services.

Much of the data, particularly that required for management as distinct from planning purposes, will need to be analysed on a district basis as well as an area basis. The community medicine specialist at district level will be involved both in its collection and in its interpretation.

PLANNING

60. In a National Health Service, major objectives and the broad strategy for their achievement must be decided nationally. The Consultative Document (paragraph 12) states that "the Central Department will determine national objectives, priorities and standards, and allocate resources to regional authorities". The regional authorities will in turn bear a similar responsibility for planning within their regions in the light of the strategies laid down centrally. The areas will be responsible for planning the use of available resources to achieve these national and regional objectives and for putting plans into action. Community medicine specialists employed by the area—and in particular the chief administrative medical officer—will play a leading part. They will draw upon their wide professional knowledge of the health services of the area as a whole and the expertise of professional advisory committees, and apply their skills in the organising of health care generally. They will be con-

tinuously reviewing existing services and advising on how they can best be developed or on what new services can be introduced within the resources likely to become available, and what services can be contracted or gradually withdrawn. In general, they will be seeking to improve the quality of care by, for example, the regrouping of resources or the improvement of facilities provided for doctors and others to do their work and also to identify the most effective but least expensive forms of care. They will study the outcome of particular health programmes (for example, the success of specific health education campaigns or treatment arrangements) and with the help of all concerned, identify the lessons to be learnt for the planning and development of future services. To carry out these functions there will need to be community medicine specialists who concentrate on different fields, and we discuss these staffing requirements in more detail in paragraphs 87–90 below.

61. Planning of services should be backed by an active research and development programme. Organisation of research in the provision of health services will be an important responsibility of the CAMO or a member of his staff. He will also be responsible for seeing that area research is related to regional research activity and for keeping the area authority appraised of the results of research carried out throughout the country. We think that every area will need to build up a research and development programme, whether or not it is an area with responsibility for providing undergraduate teaching facilities.

MANAGEMENT OF HEALTH SERVICES

62. It is often suggested that there must be conflict between the administration and the medical profession on the management of resources. This is based on a misunderstanding, as the aim of both is better patient care. Those who stand to gain most from the better management of resources are patients, whose doctors need, for example, new equipment or more staff to do a better job by the most up-to-date methods. We see no conflict between management and the profession collectively, although there may be difficulties to be resolved for particular specialties which no longer need the same facilities—beds, equipment and staff—which were allocated to them in the past. For example, with the changing pattern of medicine there has been a sharp reduction over the past two decades in the need for certain categories of beds, such as those for infectious diseases. A considerable redeployment of resources has taken place, but it has not proceeded as far or as fast as we consider would have been desirable. One reason is because there is at present no doctor at what will be area or district level with a clear responsibility to ascertain where medical resources could be saved and better deployed. We see this as an important responsibility of specialists in community medicine, though it will not rest with them alone to decide how resources should be deployed; this will be a matter for area or district management, and clinicians will continue to carry responsibility collectively and individually for resources allocated to them.

63. The community medicine specialist's two main tasks in relation to management will be:

i to monitor and evaluate the operation of all health services, including their working relationships with related services provided by central and local government and by voluntary bodies; and

ii to promote improvements in the organisation and delivery of health services within available resources.

These functions will be carried out in relation to all services within the area, for example, in promoting the adoption by the authority of new area policies in particular sectors in the development of better primary care services. The community medicine specialist will not, of course, have sole responsibility for these matters. The deployment and responsibilities of community medicine specialists will depend to some extent on the nature of the management structure at area and district levels and the place of the professional advisory machinery in management. However, it seems to us that in areas containing more than one district, there will need to be a broad division of general management functions between area and district; we assume that a district management team will be responsible for the day-to-day operation of most services, and that the job of the area chief officers will in the main be to recommend policies for adoption by the authority, to allocate resources, and to monitor the effectiveness of district management in carrying out agreed area and district policies. There may be some services which are organised and provided on an area basis, but most services concerned directly with people will be carried out in operational units, which we assume will fall under the supervision of district management. Much of the work we describe below would therefore fall to the community medicine specialist working within the district—the district community physician.

64. In the district, as at the area, the health information system will be used to monitor services. Because of his training and skills, the community medicine specialist must take a lead in building this up, and in the systematic development of indices to measure the performance of health services. This will require community medicine specialists to work closely with the clinicians concerned in the collection and interpretation of data, and reinforces the need we see for a community medicine specialist at district level who can establish a good understanding with clinicians both inside and outside the hospital. A complementary role will be the promotion of improvements in the delivery of health services, which again will involve close working relationships with clinicians.

65. In the early years of the re-organised service, community medicine specialists will be looking particularly for ways of improving services through integration. The key sector in this process of integration will be general practice, which, possibly, has suffered most from the divided structure of the health service.

66. Over the past decade, more and more general practitioners have been pressing their demands for the supporting facilities needed to do their job really well. Despite the progress made in recent years, probably only about one in four of general practitioners work in purpose-built or specially adapted premises; in 1970 only about a half had home nurses working with them in attachment or liaison schemes and less than half were teamed up with health visitors. It is still very rare for consultants to hold sessions with general practitioners in the latter's premises. Though there has been a trend for general practitioners to work together in large groups, in 1970 almost a fifth of general practitioners were still working single-handed, and nearly a half in groups of two or three. The Royal Commission on Medical Education favoured groups of 12 in urban

areas and the recent report by a sub-committee of the SMAC favoured groups of five or six.*

67. General practitioners are independent contractors, and thus have the right to fulfil their contracts in single-handed practice and to work in isolation from health visitors and nursing staff if they wish to do so. In remote rural areas, single-handed practice may be imposed by the facts of geography. But what is wrong is that the organisation of the health service should make it difficult for general practitioners who wish to do so to develop domiciliary teams or work together in larger groups in purpose-built premises. The establishment of an integrated health service will reduce the administrative barriers in the way of such developments. It will be necessary for the community medicine specialist to ascertain the wishes of local general practitioners and to work out plans with others concerned, for example, the chief nursing officer, by which they can be met as far as possible, within the limits of the manpower and financial budgets of the area authorities. He will liaise with appropriate local organisations to provide where necessary the medical assessments required to establish priorities in cases where requests cannot be met in full. Some general practitioners may wish to conduct their own negotiations with other practitioners and to acquire their own premises. Even here the knowledge and experience of the community medicine specialist can be of value, through his knowledge of wider developments being planned for the area, including the deployment of the personal social services. Other general practitioners may be glad to have the community medicine specialist explore the various alternatives on their behalf and provide a plan which they, as independent contractors, are free to accept, amend or reject.

68. Contact between general practitioners and community medicine specialists will extend far beyond help with obtaining suitable premises and the attachment of staff. The community medicine specialist will come to know the special interests and skills of particular practitioners so that they can be fully used in the work of the area authority. He will know those who have interests in research, and will be in a position to assist with access to relevant research and computer facilities, and to offer help and advice; or to put the practitioner in touch with those better equipped to advise or act as collaborator. An important aspect of his work will be to provide, or help general practitioners provide, on an adequate basis of mutual confidentiality, the epidemiological and other statistical data they will need.

69. General practitioners will need the support not only of the local health services but also of the personal social services. They will also need to work closely with local social workers who are also advising the same families. While general practitioners will channel their own requests to social services departments, there will be occasions when services which appear to be essential for their patients are not provided, and where co-operation appears to be breaking down. In such circumstances, the general practitioner will be able to pass on those difficulties which he is unable to resolve himself to the community medicine specialist, who will be able to make direct representations to social services departments.

* The Organisation of Group Practice: a report by a sub-committee of the Standing Medical Advisory Committee (Central Health Services Council), HMSO, 1971.

70. The establishment at district level of a medical committee on which all doctors are represented will be an important step in establishing closer contact between consultants and general practitioners. The further development of continuing education by the area and the region, in association with the university, will also help to bring together doctors practising primary care and those in the hospital. It will be the task of the community medicine specialist to advise on what further links can be forged by appointment of general practitioners in hospital and by sessions held by consultants in health centres and group practice premises. Under a unified service there should be more opportunities for the general practitioner and consultant to work together, particularly by pooling their skills and knowledge and by devising together treatment plans for individual patients.

71. So far as general practice is concerned, the community medicine specialist will in many areas have to start virtually from scratch in building up the health information which area and district management will need. Within the hospital, on the other hand, a considerable amount of information is already collected on a routine basis and is expanding rapidly through, for example, the introduction of hospital activity analysis. There is also a lot of statistical material available in local authority health departments. It will be the task of the community medicine specialist to marshall this information in a form suitable for decision making. He will have a special responsibility for assessing the outcome of medical care services generally and for initiating local studies to throw more light on critical areas.

72. Consultants frequently complain that their beds are blocked by patients no longer needing the services of a particular unit or of a hospital. At present, consultants are often expected to resolve these problems unaided while continuing with their heavy responsibility for providing a clinical service. In the future, the community medicine specialist will learn of the problems encountered by particular consultants and attempt to find solutions. Similarly, he will be able to work out with consultants what would be required to extend the scope of out-patient surgery, to develop a day hospital, or to try out an early discharge policy and monitor the medical, social, psychological and economic effects of that policy as compared with existing methods.

73. Redeployment of resources may be needed to improve quality of care. It will be many years before each district has rationalised the grouping of its hospital resources. Many authorities will have to continue to manage their district services in a number of different hospital units of varying size. Medical work of a particular kind may need to be channelled to only one of the district's hospitals, and this may involve the redeployment of medical manpower within the district. It will be the task of the community medicine specialist to ascertain where greater concentration of patients and the resources needed to treat them is required to secure an even quality of care at as high a standard as possible within the resources allocated to the area.

74. In addition to their main responsibilities in monitoring and promoting improvements in health care generally, we think that, at least in the evolutionary early years of the re-organised service, community medicine specialists should be responsible for the organisation of those personal health services (excluding the nursing services) which are at present the responsibility of local health

authorities but which will be transferred to the new area health authorities, and also for the medical services provided at present as a part of the school health service. (We do not know whether responsibility for the school health service will be transferred to the new area health authorities, though we believe this would be desirable, but whatever decision is reached, we think that the medical services must be provided by doctors within the health service.) We also think that community medicine specialists should see that the necessary measures are taken to discharge the area health authority's responsibility for the prevention of communicable diseases through specific prophylaxis and treatment (control of communicable disease generally will be the responsibility of the new local government district authorities) (see paragraphs 81–84).

75. Community medicine specialists will not be personally concerned in the clinical work involved in these services; for example, at child health clinics or in school health inspections. The pattern of organisation and delivery of these services varies considerably; a significant part of the clinical work will no doubt continue to be performed for some time to come by the doctors currently employed on clinical work by local authorities, often on a part-time basis. Such doctors will doubtless transfer to the new health authorities. There is a trend towards greater participation by general practitioners in these services which we welcome and hope will continue. In recent years too there has been a growing interest amongst hospital paediatricians in the wider aspects of child health care. We do not know how in the long term these services will evolve, but for the foreseeable future it will be a part of the community medicine specialist's remit to promote the development of an integrated child health service, including the school health service.

76. Similarly, specialists in community medicine should carry a prime responsibility within the unified service for the planning and organisation of programmes for the promotion of health and the early detection of disease, including medical advice on health education (which will be a responsibility of both the area health authorities and the new county and district authorities). In this work he will need to work closely with clinicians, including those in general practice, and with colleagues in other health and social service professions, nurses, midwives, health visitors, social workers and teachers.

ADVICE AND ASSISTANCE TO SOCIAL SERVICE AND EDUCATION AUTHORITIES AND OTHER BODIES

77. We have not thought it appropriate to consider in detail what arrangements should be made for the provision of medical advice from area health authorities to local education and social service departments and district local authorities, as these are an important part of the remit of the working party set up by the Secretary of State to advise him on collaboration between the National Health Service and local government. We would, however, emphasise that whatever formal arrangements are made for this purpose there must be clear recognition by everyone of the interdependence of the health and social services. Unless this is recognised and acted upon, then neither authority will be able to provide the best service, and much of the potential benefit of the re-organisation of both health and social services will be lost. It is obviously essential that the planning of health and social services should be closely co-ordinated, so

that the implications of varying strategies of care for both services are properly assessed and decisions reached which take full account of them. We have already stressed the need for integrated health and social service information arrangements.

78. We envisage that, at officer level, it will be the job of specialists in community medicine to act as the chief source of advice to the social service authorities, and that the head of the social service department will occupy a similar role in relation to the health authority. At area level, we would expect the chief administrative medical officer formally to take responsibility, although as in other matters, he will not only bring his own particular knowledge and expertise to the work, but will also seek and transmit to the social services authority the collective views of the medical advisory machinery and of the health authority itself as occasion requires.

79. We would expect the CAMO of the area health authority to act as the chief medical adviser to the education authority. The continued development of the school health service and its integration within the child health services generally will be an important responsibility of community medicine specialists, and they will need to maintain close relations with teaching staff and other officers of the education authority. It will be especially important that they enlarge the corpus of knowledge of the special educational requirements of handicapped children.

80. In addition to providing advice and assistance to the social services and education authorities, we think that specialists in community medicine should also undertake the functions, at present discharged mainly by medical officers of health, of providing medical advice to other local services and to voluntary public bodies. In the voluntary field this will be particularly so as regards those bodies who provide agency services for the health authority, for example, in relation to family planning. In addition, medical advice will continue to be needed in relation to a wide range of functions, for example, housing, building design, planning, consumer protection. However, where the advice required is primarily clinical in character, then we would not see it as the responsibility of the community medicine specialist to provide it.

MEDICAL SERVICES REQUIRED BY LOCAL GOVERNMENT AUTHORITIES IN RESPECT OF ENVIRONMENTAL HYGIENE AND COMMUNICABLE DISEASE CONTROL

81. Responsibility for environmental hygiene and communicable disease control (other than by specific prophylaxis and treatment) will remain with local government district authorities. Medical services and advice will be needed in respect of:—

i Environmental hygiene, including the quality of water supplies, the disposal of wastes and the prevention of nuisances, clean air programmes, and also housing and planning matters.
ii Food hygiene, food safety and food-borne disease.
iii Control of communicable disease.
iv Port health (where applicable).

If the Government's bill for local government re-organisation is enacted, the responsibility for these matters will rest with the metropolitan districts and the districts within provincial counties, and it will be only in the metropolitan districts that boundaries will coincide with those of the new area health authorities. Local government district authorities within counties will not necessarily cover the same localities as the districts within area health authorities.

82. Under existing legislation, medical officers of health have a large number of statutory responsibilities and a general duty to inform themselves on all matters affecting or likely to affect the public health, and to advise the local authority. Their responsibilities require them to build up a detailed knowledge of their localities and to keep, either directly or through medical and other staff (principally the public health inspectorate), a close watch on developments to ensure that prompt action is taken to deal with any circumstances likely adversely to affect the public health. The new arrangements for the provision of medical service to the local authorities of the future should, we think, continue to reflect the need for the doctor concerned to have a close knowledge of the locality for which he has responsibility, and to be known and readily accessible to local government officers and general practitioners—particularly in the field of communicable disease control. This will be essential whatever arrangements are made within a re-organised service for discharge of the present statutory responsibilities of the medical officer of health.

83. We consider it of vital importance that the local government districts should look to doctors in the National Health Service trained in community medicine for the advice and services they will need. It is amongst such doctors that the necessary expertise will be found, and their joint responsibilities towards health authorities and local government will help to ensure the co-ordination of overlapping responsibilities. The days when a single doctor could have expert knowledge of all aspects of those health matters which will be the responsibility of local government districts are past, and to carry out their future work effectively we are sure that such medical advisers should be part of the health team, so that they will be in a position to draw fully on the wide knowledge and expertise within the NHS. We anticipate a growing need for specialist advice as the health hazards created by modern industrial and urbanised society continue to multiply and increase in complexity. For that reason alone it is most important that medical advisers to local government should be within the framework of the NHS and thus have ready access to expert advice on specialist matters, some of which will be available at regional or national level.

84. The lack of correlation between the new local government districts within provincial counties and the area health authority and its component health districts may be a possible cause of difficulties. Local Government district authorities will naturally wish to have their own medical advisers accountable to them for the work they do in helping to discharge the authority's statutory responsibilities. It will obviously be desirable to avoid situations in which, within the boundaries of a single area health authority, local government districts receive different medical advice on the same or similar problems. We appreciate that it will be necessary to have arrangements in this field which are acceptable to both the local government and health service authorities and we understand that this matter is being considered in detail by the working party

on collaboration between the new local government and health service authorities. Co-ordination of advice to local government districts within the boundary of an area health authority would be most desirable and we think that the area CAMO would be the natural person to undertake this function.

PROFESSIONAL ADVISORY MACHINERY

85. The Consultative Document refers (paragraph 18) to the intention to see that strong professional advisory machinery exists at area level. It is not for us to say what form this should take, but we would expect that clinicians would be strongly represented on any professional advisory bodies and we regard it as an integral part of the duties of the CAMO and other community medicine specialists to see that the expert professional advice of clinicians is sought on all appropriate matters. It will be part of the responsibilities of the community medicine specialists to see that advisory committees have adequate professional services and information to do their job effectively.

86. Professional advisory machinery will be equally important at district level, and at that level clinicians will also need to examine collectively the organisation and discharge of medical work within the district in order to fulfil their clinical management responsibilities. We refer to this need in the next chapter when we discuss the status of the district community physician.

STAFFING

87. We have outlined above the main functions we see for specialists in community medicine working for the area health authority. The establishment will clearly vary in size according to the size and complexity of the area. However, each area will have a chief administrative medical officer. We do not think that it is essential for the proper discharge of his duties that he should be appointed as the chief executive officer to the authority, though should such posts be created, we think he would be a strong contender for them. If the top management responsibilities are discharged by a group of chief officers to the authority, then the chief administrative medical officer will be an essential member of the team, which should, in our view, be kept as small as possible. Whatever arrangements are adopted, however, it is essential that the chief administrative medical officer be regarded as a chief officer of the authority with direct access to it. As regards his relations with doctors and others not forming part of the headquarters administration of the area, we think there is much merit in the concept of the chief administrative medical officer acting as a staff officer of the authority, which would enable him to speak as the agent of the authority but without any hierarchical authority.

88. The division of duties amongst other community medicine specialists employed by the area authority must clearly be left to the discretion of the authority in the light of its particular needs, and to the experience, skills and aptitudes of the staff available. However, we would think it likely that an area comprising, say, three districts, each with around 200,000 population, will have a need for at least three community medicine specialists at area level in addition to the CAMO, and for a specialist engaged wholly or substantially at dis-

trict level in each district. We think these figures represent minimal requirements. At area level the main functional categories of work might be:—

i Information services, including responsibility for organisation of epidemiological studies and statistics. The doctor primarily concerned might also be engaged on forward planning, though we would expect the CAMO himself to be heavily involved in this.

ii Medical staffing, training and personnel work.

iii Specialist sectors of health services in which the involvement of community medicine specialists is desirable to ensure effective provision and development. These include the promotion of health and early detection of disease, and services (for example, for children, the aged and mentally disordered) where it is essential that there is effective liaison and integration, not only within the health service but also with the social services, education services, Government Departments and voluntary agencies.

89. Division of functions at area level between community medicine specialists will enable—and indeed require—staff to develop special interests and skills. We would not, however, wish to see the development of a functional sub-division leading to a restrictive narrowing of career opportunities for community medicine specialists, who should be regarded by their training as qualified to move widely within the field of appointments in community medicine at area level and above, although, of course, for particular jobs further specialised training may be required. We refer to this again in our chapter on training.

90. It has been suggested that there might be particular types of specialists known, for example, as community paediatricians, community geriatricians and community psychiatrists, whose work would be entirely or largely outside rather than inside the hospital. Whatever may finally be decided, such clinicians should not be confused with community medicine specialists, whose expertise lies outside the clinical field and whose contribution to the work of his colleagues lies primarily in the epidemiological and organisational aspects of health care.

ANNUAL REPORTS

91. The long sequence of annual reports in their traditional form by medical officers of health must clearly come to an end with unification of the personal health services. While we recognise that it is for others to determine whether area health authorities should annually publish a report of their activities, and, if so, what form this should take, we think it would be desirable for area authorities to be accountable to the public in this way. The CAMO should contribute a section to any regular report made by his area authority and his contribution should be regarded as his own personal report.

CHAPTER V

THE STATUS AND FUNCTIONS OF THE DISTRICT COMMUNITY PHYSICIAN

92. We have suggested in the previous chapter the broad outline of work we see for community medicine specialists employed by the area authority, and

have indicated that a considerable amount of this work will require a community medicine specialist knowledgeable about and operating within the health service district. We consider that there is a substantial job to be done by a "generalist" community physician in a career post for a district sized population. The job would be such as to attract a doctor who would be considered by those in the clinical field to be of consultant calibre. The length and quality of training required would be similar to that necessary to obtain a consultant post in the clinical specialties. (We discuss training in detail in Chapter VI.) The post would, therefore, be a senior appointment of a similar status to that of consultant.

93. We have given very considerable thought to the status of the district community physician and in particular to his relations with the area authority and with clinicians within the district. An important part of his role will be akin to that of those clinicians, such as radiologists and pathologists, who provide a service to their clinical colleagues to enable them to fulfil their responsibilities more effectively. We discussed how the community medicine specialist might assist clinicians, particularly in the discharge of their clinical management responsibilities, in Chapter IV (paragraphs 62–76). In these respects in matters of professional judgement he would speak as a fully trained and senior doctor in his specialty in the same way as consultant clinicians. Like his clinician colleagues, he would participate in the work of the local medical advisory machinery. At present there are various kinds of medical advisory bodies—for example, in general practice, local medical committees, and within the hospital service, either medical executive committees constituted from the functionally based "divisions" (the "Cogwheel" structure) or geographically based group medical advisory committees. More and more hospital groups are adopting Cogwheel arrangements, although there are many local variations. Some groups have made considerable efforts to provide a bridge between hospital and primary care services by providing for representation of general practitioners and local health authority medical staff.

94. It is not for us to say what should be the medical advisory machinery at district level in a unified health service—for example, whether the functional representation principle should be extended to embrace clinicians outside as well as in the hospital or whether a separate advisory machinery will be needed for them. However, we are sure that there will be a need for some mechanism to enable clinicians to participate in the forming and implementation of policy at district level, and to study collectively the organisation and carrying out of medical work within the district. Whatever shape these arrangements may take, we are sure that the district community physician, because of his investigative and analytical skills as a specialist in community medicine, will have an invaluable part to play in ensuring that these arrangements are able to work effectively.

95. We assume that, in addition to this professional advisory machinery, there will also be at district level a management team, multi-professional in character and responsible to the area authority for some or all of the service within the district. If this is so, we would expect that within this team there would be representation of district medical interests chosen by medical colleagues in much the same way as the chairmen of the hospital medical executive

committees and local medical committees in general practice are at present. We believe that a district community physician must be a member of the team. We make this recommendation because we believe such a position is essential if he is to fulfil effectively his task of promoting the efficient use of resources, and if his training, both in management of health services and in the professional skills of community medicine, is to be put to best effect. We have considered whether giving the district community physician a place on the district management team might be interpreted as in some way creating a medical manager, akin to a medical superintendent, not responsible in the way, for example, that a hospital Cogwheel chairman is at present to clinical colleagues. We have also considered whether such an appointment might undermine the effectiveness of any representative medical advisory machinery. We certainly do not think that either development would be in the interests of the health service, but we do not believe that the appointment of the district community physician to the management team carries with it such implications. Membership will ensure that his expertise is readily available to the rest of the team and will give him a share in the collective responsibility to the area which the management team will have; with the agreement of the district management team, he may undertake particular executive tasks within the health service district. But his appointment as district community physician would not of itself give him any such responsibility, and we certainly do not see him in any way as a threat to the established and necessary clinical freedom—and responsibility—of his clinical colleagues. We do not think it would be desirable for any members of the management team to have a directing authority over the others, who will be experts in their respective fields; but we recognise that one person will need to be given co-ordinating responsibilities for the team.

96. We envisage that the relationship between the district community physician and the headquarters officers of the authority would be similar to that between other district officers and area officers. We think it would be compatible with the concept of a district management team exercising corporate responsibility if they were responsible collectively to the area authority; individuals would not then, as members of the team, be in a hierarchical line relationship with chief officers at the area. We think that this would be satisfactory in regard to the responsibilities undertaken by the district community physician as a member of the district management team. However, we think that a district community physician might also be given other responsibilities within the area as a whole, or a part of it, which were distinct from the responsibilities of the district management team, for example, in relation to services organised on an area rather than a district basis, or for the provision of advice and services to local government. He would be accountable to the area CAMO for services organised on an area basis; where he was appointed as adviser on environmental hygiene and communicable disease control to the local government district authority, he would be directly accountable to it for these matters.

97. We have not attempted to set out in detail the functions of the district community physician or to provide a precise job specification, but we think that the main elements can be summarised broadly as follows:—

i As a specialist in community medicine, he would build up and maintain a health profile of the district through the collection and analysis

of relevant statistical and other data, and contribute to the health information input of the area. He would participate with colleagues in research into the aetiology of disease and its association with social and environmental factors. He would make available to his consultant colleagues on an advisory basis his knowledge of the district and his expertise in the organisation of health care. He would be particularly concerned with developing services or activities for the promotion of health.

ii As a member of the district management team, he would take part in the preparation of suggestions for the area health authority on the development of area plans and policies, and participate in their implementation within the district. He would be concerned to promote the integration of health services, and generally to monitor the quality of health care provided in the district and to identify ways of rectifying deficiencies. He would also be concerned to promote the development at district level of effective working relations between the health services and the other social services provided by the local authorities, Government Departments, and voluntary bodies. He would share with his colleagues responsibilities also for the promotion within the district of good relations between the health services and the public generally, for example through providing information and other assistance to the local community health council.

iii As a member of the group of community medicine specialists of the area health authority, he would carry out functions falling outside the responsibilities of the district management team, relating to services which might be organised or administered on an area rather than a district basis or relating to local government services.

98. We have not quantified in terms of workload the functions of the district community physician. This will be to some degree dependent not only on the size and nature of the area and district concerned but also on other variables such as the organisation and management of health services within the area as a whole and the number and deployment of the CAMO's area medical staff. But the work will certainly be demanding. We regard it as of vital importance that district community physicians should be able to discharge their responsibilities effectively and to this end some of us believe that it may prove desirable for more than one such specialist to be appointed in some districts. However, we would all agree that it will be essential to ensure that all doctors appointed as district community physicians are of the high calibre needed to meet the requirements of the post.

99. We have suggested that an important responsibility of the district community physician will be to provide a specialist service for clinical colleagues, and we have likened this to the situation of a radiologist or pathologist (paragraph 93). We are aware, however, that there is a distinction to be drawn between the function of an established service department to which clinicians are accustomed to turn for information and co-operation, and the role which we now suggest for a district community physician, the value of which may not be immediately apparent to all his colleagues. We have no doubt that the district community physician as we have sought to describe him will be essential to the future well-being of the service. We do, however, believe that time and

opportunity must be allowed to him for the satisfactory development of his responsibilities, and much will inevitably depend upon the acceptability of his personal qualities and his professional ability.

CHAPTER VI

TRAINING AND CAREER STRUCTURE

100. The work of community medicine specialists within the NHS should offer exciting and challenging prospects to young doctors. But this will not in itself attract to the specialty a fair share of the best medical talents. There are two requirements which must be met in order to recruit specialists in community medicine of the necessary calibre in the numbers needed. First, a better training programme must be established for young doctors entering the specialty. Secondly, this training programme must lead to an attractive career structure.

101. We have in earlier chapters described the role we see for the specialist in community medicine within the administration of the National Health Service. The work we envisage is at present being undertaken in varying degrees by doctors employed by local government and regional hospital boards, but overall much less is being done, particularly as regards the systematic assessment of needs and services, than we believe is necessary in the future. Part of the present deficiencies arise from a lack of suitably trained doctors with the necessary skills. We argued in our interim report (see Appendix E) the need for retraining of doctors at present in medical administration to prepare them for the tasks ahead, and we are glad to see that this has been accepted by the Government and that arrangements for retraining are going ahead.

TRAINING

102. In the opening chapter of our report we explained our reasons for regarding the mainstream of medical administrators as specialists in community medicine. In considering training we have therefore looked primarily at training within the specialty of community medicine. The development of comprehensive training within this specialty is still in its early stages; the Faculty of Community Medicine of the Royal College of Physicians has yet to define any programme or standards of training and there are considerable problems in developing training along the lines of other specialties.

103. There is no recognised training grade for doctors in local government but arrangements for training are made. The traditional pattern of training of doctors in administrative medical posts in local government has been for them to undertake a full-time university course, usually of one year, leading to the Diploma of Public Health or other qualification recognised by the General Medical Council as equivalent. Such qualifications are currently a statutory requirement for doctors holding posts as medical officers of health. Our proposals assume that such a requirement should not be transferred to senior posts within the reorganised service. The administrative medical staff of regional hospital boards and the central Health Departments are not required to have any postgraduate qualifications, and although some hold the DPH, by no means all do. In regional board service there is a training grade of medical officer which equates with the

hospital grade of senior registrar for pay purposes, but there are relatively few appointments made and the arrangements made for training in the grade are variable. Attempts are currently being made to provide integrated programmes of in-service and formal academic training but no clear pattern of development has yet emerged. Doctors in the central Health Departments may undertake appropriate formal training courses, but, as in local government, there is no recognised training grade.

104. We are aware of both the difficulty and the danger of trying to define in too much detail how training might be developed in future. It is difficult, because the precise jobs which will be done within a unified service and the numbers who will in practice be required are not yet known; it is dangerous, because it would be wrong to recommend a particular organisational pattern of training to the exclusion of other possibilities. We believe that any training arrangements must be regarded as experimental and kept under review in the light of experience. However, we do think that there are certain basic requirements which training should meet. We describe these below, together with some of the related issues concerning the organisation of training.

GENERAL POSTGRADUATE TRAINING

105. We think it desirable that before entering specialised postgraduate training in community medicine, a doctor should have a minimum of two years' post-registration clinical experience; some of this time should preferably be spent in general practice or in other clinical work outside the hospital. We do not think it would be desirable at this stage of development of the specialty to adopt a rigid definition of essential clinical experience, and we expect that for some years to come the previous experience of doctors wishing to undertake specialist training will vary widely.

SPECIALISED POSTGRADUATE TRAINING

106. The pattern of training in other medical specialties is towards a three or four year period of higher or specialised training. The length of specialised training required for community medicine must be determined by what in practice appears to be necessary, but we envisage that a training period comparable in length to most clinical specialties will be needed.

107. A major element in a specialised training period of this length will necessarily be in-service experience in suitable training posts, following the pattern in other specialties where there is a tradition of supervised in-service training. In addition, we consider that there will be a continuing need to provide opportunities for formal academic study. At present, opportunities for such study are, with few exceptions, limited to the full time courses of one year's duration leading to the DPH, or, in the case of courses leading to an M.Sc in Social Medicine, two years divided between academic work and practical field training supervised by the university authorities.

108. The introduction of, say, a four year training period will call for a co-operative effort between academic and professional bodies and health service

authorities to ensure that the varying training experiences are properly integrated so as to provide a coherent programme whilst allowing for some flexibility of choice for the individual. We are aware of the strongly held views of some university teachers with wide experience in this field that it is essential for new recruits to community medicine to have as an introduction to the specialty a period of about a year's continuous full-time academic study, in order that the teaching of the various elements of the discipline can be satisfactorily synthesised and the student can obtain a proper understanding of their inter-relationship. Most of us think, however, that there is room for alternative approaches to be considered and that there might be advantages, both to doctors in training and to service and academic authorities, in developing arrangements whereby formal academic study was spread over a number of modular elements of courses which might provide in all about the equivalent of up to an academic year's full-time study, but spread over, say, two calendar years. As a general rule, formal courses would be based on university departments and each element might involve several weeks of full time study. Between these elements doctors would be gaining experience in training posts. If maximum benefit is to be gained from training, it is obviously desirable that the in-service experience should relate as closely as possible to the academic component; this will be more readily achieved if the university departments involved in academic teaching have close contacts with the service authorities, and particularly if, as on the clinical side, university teaching staff hold honorary NHS appointments for the provision of specialist services to the health service authorities. We discuss this crucial point in more detail in paragraph 127 below.

109. We do not want to describe the detailed content of training, and again we think that any recommendations at this stage must be to some degree arbitrary. However, we consider that all doctors aiming at a career in the mainstream of administrative medical work in the NHS should, preferably during the first two years of specialised training, undertake formal full-time study in each of the following subjects:—

Medicine and Human Biology

The application of medical and biological knowledge to the promotion of health, preventive medicine and the organisation of medical care.

Epidemiology and Environmental Health

Including principles and methods of epidemiology; sources of information; design of experiments relating to health services; epidemiology of communicable and non-communicable disease; and control of communicable disease.

Statistics

Including basic statistical methods; survey analysis and data processing; use of computers; vital statistics and demographic trends; social statistics; and the design of health service information systems.

Social and Behavioural Sciences

Including study of social conditions in the community; behaviour, particularly in relation to health and disease; non-physical factors in illness and disability; family relations; sociology of the professions; inter-professional relationships; and dynamics of social change.

Social Administration

With special emphasis on the health and relevant local government services, including their development, organisation, and finance, and international comparisons.

Health Service Management

Including principles of planning, provision and evaluation of health services in all aspects, and an introduction to relevant management theory and practice.

110. The detail and level of teaching necessary in these subjects will vary according to the extent to which undergraduate curricula come in time to provide a more adequate introduction to community medicine. It may occasionally be possible and convenient for some elements within this training to be taken along with non-medical staff where their needs coincide. We would, however, doubt whether this will very frequently be practicable and we would not regard multi-professional training as so important during this basic training period as later on (see paragraph 111 below).

111. An academic training on these lines, linked to suitable in-service experience would, in our view, provide a good basic training. It will be essential that, during their basic training, all doctors should receive thorough field training experience, under supervision, in practical epidemiology: that is, in the techniques for investigating the health of populations and monitoring trends; for measuring the requirements of populations for health care and preventive services; and for assessing the activities, efficiency and effectiveness of the services provided. Further specialised training in particular subjects should, however, be available for doctors training in community medicine who wish to make a career in particular specialised fields, for example, medical information science, either in university work or in specialist health service posts. It would be desirable that doctors aiming at administrative medical careers within the NHS should, after they have completed their basic training, have the opportunity to attend multi-professional courses in health and social services management at an appropriate level. We attach great importance to the development of multi-professional training in management which has been too long neglected.

112. Doctors trained in community medicine may enter health service authorities, the central Departments, or universities and other teaching or research oriented bodies. Those wishing to enter teaching or research may pursue a rather different training pattern from those aiming at a health service career, but in principle it would be desirable, as in the clinical field, to provide as far as is practicable for movement between health service and academic posts during

training. Any assumptions about numbers are necessarily arbitrary, but on the basis of a figure of, say, 1,000 trained community medicine specialists (including those working in the central Departments, as well as regional and area health service authorities), serving for about 30 years on average in career posts, and assuming about a four year training period, the number of trainees in post at any one time would have to be in the order of 130–160, which would require an intake of about 30–40 a year or 2 or 3 trainees per health service region. The figure 1,000 is not a prognosis of need and we use it simply to indicate that while all medical schools should teach community medicine at an undergraduate level, academic teaching at a postgraduate level will need to be restricted to a more limited number of centres. Indeed, if academic postgraduate education were in the form of an integrated continuous training course like the present DPH/MSc courses, two or three centres might suffice for England and Wales (though it would be desirable to include some capacity also for overseas doctors).

113. In considering the arrangements which might be made nationally for postgraduate training, it has been necessary to weigh up a number of factors. If the academic training were concentrated on two or three centres, it would be most unlikely that the health service authorities with which the centres were immediately associated could provide enough suitable in-service training posts, and it would, in any case, seem to be desirable that in-service training should not be concentrated in a small number of regions, but that each region should provide some training capacity. If, however, in-service training is to be spread over all regions, it will make it more difficult for, say, two or three university departments to co-operate with all the service and other authorities concerned in securing that in-service experience and training are adequately related. This difficulty might be reduced if academic training were provided at a larger number of centres with no one centre providing a fully comprehensive teaching programme. If such academic centres were firmly associated through their research and other activities with the related health service authority, suitable in-service experience might more readily be integrated with the academic training. This approach might be particularly suited to the teaching and practice of epidemiological methods and statistics. Training on these lines would be greatly assisted if in most, if not all regions, university departments undertook relevant health service research or intelligence functions on behalf of health service authorities. Such developments are already taking place at a number of universities, which suggests that a start on an experimental basis might be a possibility. An advantage of providing training through a number of centres would be that it would be possible to use the scarce professional resources possessed by each centre, which might otherwise remain untapped for postgraduate training purposes. Given the relative shortage of teachers of community medicine, it is difficult to overemphasise the need to make the fullest use of the available talents.

114. The involvement of a number of different centres in the provision of a programme of academic training would, however, create some problems, such as the difficulties involved in ensuring a consistent teaching philosophy, avoiding repetition, and in developing a close understanding of the particular needs of individual doctors. It would also complicate any processes of assessment. But these factors do not in our view constitute over-riding objections, and we think the practicalities and possibilities of training on these lines should be explored further. On the other hand, we do not think that it would be right to abandon

the more traditional approach of a single university centre providing a comprehensive academic course. We think that both main types of approach should be tried so that their relative merits can be properly considered in the light of experience.

115. The development of suitable in-service training posts will be a major joint responsibility of the new health service authorities and the academic and professional bodies concerned. We have suggested that some in-service experience should be in posts either within or closely associated with university or other (for example, MRC) departments engaged in health service research or intelligence. We think that this will be particularly important during the first two years or so of training, when a young doctor will be engaged for a substantial amount of time in academic work, and supervision of practical field work by academic staff engaged also in teaching would be particularly valuable. Subsequently, however, it would seem desirable that in-service experience should be obtained in a range of posts away from university centres, and this should include some experience at district level.

TRAINING FOR MATURE ENTRANTS

116. Both central Government and NHS authorities have in the past recruited into medical administrative work significant numbers of doctors relatively late in their careers, for example, after service in the Armed Forces or Government service abroad. We are convinced that, in future, community medicine must seek to obtain most of its recruits from doctors who make the specialty their first choice as a career. However, we think that it will be important for the foreseeable future to provide arrangements whereby entrants may receive formal training in community medicine. It would be unrealistic to expect all of them to take a full four years in training. Opportunities for retraining in particular aspects of community medicine should be open to them, and in some cases, for example, clinicians with experience in epidemiology, their previous careers may make them particularly suited after retraining and some in-service experience to occupy certain specialist posts. Inevitably, for most later entrants the field of opportunity is likely to be more restricted than that of the doctor who has undergone a full basic training. Development of a number of academic centres, each specialising in different aspects of training in community medicine, should assist in the provision of training for mature entrants by making it possible for them to receive training in particular subjects without undertaking a fully comprehensive programme.

CONTINUING EDUCATION

117. As in other specialties, it will be necessary for the specialist in community medicine to have opportunities for continuing education to develop his skills and knowledge and to keep abreast of developments in his specialty. Again, this should be facilitated by the involvement of a number of regional university centres in postgraduate teaching and research, and the creation of close operational links between such units and health service authorities. The experience gained by university centres engaged in short term retraining of medical administrators (as recommended in our interim report) should prove

useful as a basis on which to build arrangements for continuing education. Where it is appropriate and practicable, continuing education should be on a multi-professional basis.

SUPERVISION AND ORGANISATION OF TRAINING

118. Hitherto, formal recognition of postgraduate training and the award of qualifications has been largely a matter for the universities, who have given degrees or diplomas primarily on the basis of examinations, though recent developments have given scope for doctors to include periods of supervised practical experience within the duration of the course. The foundation of the Faculty of Community Medicine opens up the possibility of additional forms of recognition. We do not know what form of qualifying experience or academic credentials the Faculty may require for membership, and whether it envisages that membership would be awarded towards the *completion* of specialist training (like the pathologists), or at an intermediate stage (like the physicians), with perhaps some additional form of recognition later to signify that, in the Faculty's view, training to specialist level had been satisfactorily completed. It would be most unfortunate indeed if, in the formative stages ahead in the development of training for community medicine, the universities and the Faculty did not work closely together. It will also be necessary to ensure that the health service authorities are involved in the administrative arrangements for training. Broadly speaking, we envisage that it will be for the central Departments and the service authorities to see that there are enough training posts, taking into account posts in academic units which may also be recognised as providing comparable training. Depending on their requirements, posts may also have to be approved by the Faculty where training leads to recognition by the Faculty. Formal teaching and, where appropriate, supervision of associated field work experience, will be the responsibility of the universities.

119. It is of great importance that training programmes for community medicine are developed as a matter of urgency. We think that this would be assisted if there were some body at a national level to advise on and stimulate action, oversee progress, and ensure co-ordination between the various agencies concerned. We think that the Council for Postgraduate Medical Education in England and Wales might convene under its aegis a body for this purpose, representative of the Health Departments, health service authorities, the universities and the Faculty. We think that any such body should include some non-medical members experienced in health service administration and training generally, although the majority of its members would be medically qualified.

120. Specialists in community medicine will be responsible along with other senior administrative and professional staff for providing leadership in the administration of the health service, and their training needs must not be considered in isolation. At present, the Health Departments are advised by the National Staff Committee on the training of administrators in the hospital service and by the National Nursing Staff Committee on management training for nurses. Any body concerned with the development of training for specialists in community medicine would clearly need to maintain good liaison with these committees or whatever bodies may replace them. If it is decided that, in the reorganised health service, there should be a single national body concerned with the development

of management training generally, then it would be desirable to include doctors within its remit. A national body of this kind would need to establish formal or informal links with any specialist advisory body concerned with the development of training in community medicine.

121. Below the national level, training within regions will come under the general supervision of the regional postgraduate committees. However, if the training involves a number of university centres, each providing part of the formal training required, it may be necessary to form two or three geographical groups of centres each providing training programmes in conjunction with the associated service authorities. Special arrangements would be necessary for supervision and co-ordination of arrangements on a supra-regional basis.

UNDERGRADUATE EDUCATION

122. The 1967 Recommendations of the General Medical Council as to Basic Medical Education stated that the objective of undergraduate medical education is to provide "all that is appropriate to the understanding of medicine as an evolving science and art, and to provide a basis for future vocational training; it is not to train doctors to be biochemists, surgeons, general practitioners or any other kind of specialist . . . the fundamental requirement is that basic medical education should give the student knowledge of the sciences upon which medicine is based and an understanding of the scientific method". We are conscious that, if this is to be achieved, specialisation must be left to the postgraduate stage. We feel, however, entirely justified in emphasising the need to provide medical students with a thorough grounding in community medicine, because in the past this has been one of the neglected areas of the curricula, particularly in the London medical schools. We are aware that in stating this need, we are recording views expressed earlier by the General Medical Council in its 1967 Recommendations, and by the Royal Commission on Medical Education in 1968, and aware also that the need is not so much for further reiteration but for action to bring about changes in the undergraduate curricula. A way must be found to overcome some of the difficult problems which have restricted progress so far. This is a complicated matter urgently requiring more study than we have been able to give it. However, a basic difficulty in the past has been paucity of staffing and investment in university departments of social medicine. The relative isolation of the staff of these departments from the health service authorities, as contrasted with the position of their colleagues in clinical departments, has adversely affected their financial and career prospects and limited the range of work undertaken. We hope that the recommendations we make about the development of postgraduate training at university medical centres engaged in health services research, and closely associated with health service authorities, will help to strengthen the resources and staffing of departments of social medicine, as well as underlining the relevance and need for the teaching of community medicine at the undergraduate level, the funding of which remains the responsibility of the University Grants Committee.

CAREER STRUCTURE

123. In considering the question of career structure we have had two primary requirements particularly in mind. First, whatever we propose must be workable

—that is, it should provide realistic staffing arrangements which effectively meet work requirements. Second, the career structure must bear comparison in terms of opportunities and rewards with other careers open to medical graduates.

124. The present medical administrators in the central Health Departments, local government and regional hospital boards work within hierarchies with varying levels of service (i.e. non-training) grades all responsible ultimately to a chief—a chief medical officer, a medical officer of health or a senior administrative medical officer. In practice, relations between officers in different grades may be informal and non-authoritarian, but there is nevertheless a hierarchical structure. We think that at central, regional and area level within the reorganised service it will be necessary to maintain a hierarchical structure, as it seems right to us that there should be a chief administrative medical officer at each level who will inevitably have to divide his overall responsibilities between other staff. At a regional and area level we think that it will be necessary to have, in addition to the chief officer grade, at least one other service grade which would be the main career grade for doctors who in future successfully complete specialist training in community medicine. Such a grade would be comparable in status to the clinical grade of consultant. In addition to posts at area and regional level within this grade, we envisage that it would also include district community physician posts, though a specialist in community medicine might frequently obtain specialist experience at area or regional level before competing for posts at district level. In the central Health Departments the nature of the work may require a more hierarchical grading structure, but we believe there should be a grade which would be recognised as the point of entry for the trained specialist. (See paragraph 131 below.)

125. We think that it would be appropriate if the appointments procedures for specialists in community medicine were as far as possible similar to those for consultants. Although there may need to be stronger representation of the employing authority than in the case of clinicians, it will be equally important to ensure adequate representation of professional interests.

126. It is not for us to make recommendations about pay matters, but we envisage that within a chief officer or specialist grade it may well be necessary to recognise that certain regional or area posts carried relatively greater responsibilities than others, and that they should be remunerated at a higher level. We especially have in mind here those posts carrying recognised responsibilities for deputising for chief officers. We have suggested that doctors in the specialist grade should be regarded as comparable in status to consultants, and one facet of this should be that their basic remuneration should equate broadly with that of consultants and should be determined by the independent Review Body on Doctors' and Dentists' Remuneration. NHS consultants undertaking work recognised as clinical are, of course, eligible for distinction awards in addition to their basic pay. We understand that about one-third of all consultants hold such awards at any one time and that about half can expect to do so at some stage in their career. Once given, awards are seldom, if ever, taken away. Medical administrators in the NHS are ineligible for such awards, and it is not open to them to engage in private practice. It is true that some medical administrators have been able to reach top posts in the hierarchy where pay is higher than the maximum point on the consultant scale (for example, the pay of senior

administrative medical officers is currently linked to the maximum of the consultant scale plus various proportions of "C" distinction award—1½, 1 or ½—depending on the regional group to which his hospital board belongs). Within a unified service such posts are likely to be achieved by a minority of doctors. It is not part of our remit to review the principles of the distinction awards system, but we wish to record our view that the restriction of such awards to doctors in clinical specialties is already anomalous and will become even more so in the future when the specialty of community medicine achieves its full potential. We are aware that in community medicine high ability may be recognised by promotion to chief officer posts. But the remuneration of these posts reflects in part the greater responsibilities they impose. If the distinction award system was extended to specialists in community medicine, it would certainly be that much easier to ensure that community medicine gets its fair share of the high calibre medical graduates it needs.

127. Another matter highly relevant to the development of the specialty is the need to ensure that the teaching of the subject is of a high standard and that adequate numbers are attracted to the relevant university departments. We have referred earlier in this chapter to the relative lack of contact between academic and service authorities in this specialty, which stands in contradistinction to the clinical specialties. In the past, university teachers in community medicine have in general not obtained honorary NHS consultant contracts which entitled them to receive identical pay to clinical consultants (although not necessarily making them eligible for merit awards). Doubt about the principle of their eligibility for such contracts has recently been removed by the University Grants Committee and the Health Departments, but they must still be able to offer to hospital authorities services on a regular basis which can be assessed in sessional terms. Unification of the services should enhance opportunities to do this. We would like to see the development of close working relationships between the relevant university departments and health service authorities. This is already happening in some parts of the country. The growth of relevant health service sponsored research by university staff into, for example, aspects of the organisation of health care, and collaboration between universities and service authorities in epidemiological enquiries and information analysis would greatly assist in this. We would hope that not only will more university teachers in social medicine obtain honorary contracts with health service authorities, but that more specialists in community medicine within the health services will be able to obtain honorary university teaching appointments. Co-operation between universities and service authorities can only be to the mutual benefit of both, and will, in our view, be an essential ingredient in the development of the specialty of community medicine, and, in particular, of the development of a sufficient cadre of teachers able to contribute to medical education at both undergraduate and postgraduate stages.

128. Turning now to the staffing structure at the training level, it would seem sensible to try to follow as far as possible the pattern in other specialties. Here the conventional pattern is for early or general professional training to be carried out in the senior house officer and registrar grades, and for further more specialised training to be in the senior registrar grade, although in some surgical specialties for example post-fellowship specialised training programmes may begin at registrar level.

129. At least for the foreseeable future, it seems to us that doctors wishing to enter specialist training will often have widely different clinical experience both in variety and duration. We do not think that at present it would be desirable to introduce strict requirements as to clinical experience, but we are aware that a consequence of this will be that some doctors may seek to enter specialty training in community medicine who would not be able, at that stage in their careers, to compete successfully for posts in the senior registrar grade. On the other hand, some doctors would be able to do so or may, exceptionally, already be senior registrars, and we would not wish them to be discouraged by not being able to begin training on the same kind of terms and conditions they would enjoy in a clinical specialty. We understand that in the hospital service at present there are arrangements whereby a doctor who reverts to a lower grade for training purposes is able, where the training is approved by his employing authority, to continue to be paid the salary he was receiving in his previous appointment. If it is decided that training for community medicine should begin in the registrar grade, we would hope that doctors leaving more senior grades in order to train in this specialty would normally have protection under these arrangements. Alternatively, there might be a special training grade created for community medicine which would provide a salary scale overlapping both the registrar and senior registrar grades, to which doctors entering training might be assimilated according to their previous experience. Under the latter arrangements, we would expect that all doctors would achieve the equivalent of senior registrar remuneration within two years of entry into training, i.e. when they would ordinarily have concluded their period of basic training in the specialty.

TRANSITIONAL ARRANGEMENTS

130. Unification will bring together a large number of doctors in community medicine of differing training and previous experience. Given their background some will merit inclusion in a specialist grade but others will not. During the transitional period, before specialists who have completed training programmes are available, we see, therefore, a need for a further service grade in addition to the specialist grade. The interim staffing structure might be somewhat similar to the present regional hospital board administrative medical staffing structure, where the principal assistant senior medical officer grade is recognised as broadly comparable in standing with that of consultant, and there is also an assistant senior medical officer grade. In time, the need for a second service grade below the specialist grade may disappear; but this will depend in part on how far the specialty of community medicine is able to attract a sufficient number of young doctors of high calibre who make it their first choice career. It would be unrealistic to assume that this can happen overnight, and no doubt for some time to come community medicine will continue to recruit in part older doctors who have considerable experience in other fields, but who will not wish to embark on lengthy training programmes or consequently expect to reach positions of high responsibility within the new health service authorities. It would, in our view, be a mistake not to make use of these doctors in positions suited to their capabilities. Nor should further advancement for them be impossible at area, regional or central level, providing individuals clearly have the necessary ability and undergo some further specialised training, as recommended in paragraph 116. We would not, however, ordinarily envisage that they would obtain posts as

district community physicians. A second service grade may also continue to be necessary for those doctors who complete specialist training but who are not able, for personal or other reasons, to obtain a specialist post without undue delay, and who wish nevertheless to pursue a career within the specialty. As in the clinical specialties, we expect such doctors would be few in number, but it would be unrealistic not to recognise that there will be some.

THE CENTRAL HEALTH DEPARTMENTS

131. In Chapter I we explained that we would not examine in detail the role of community medicine specialists in the Department of Health and Social Security and the Welsh Office, but that we considered it essential that there should be a two-way movement of staff between the central Departments and regional and area health authorities. Such movement is of great importance not only to the development of a satisfactory career structure but also to the planning and management of the National Health Service. It seems to us that it will be necessary to establish posts within the Departments formally designated for training in community medicine and integrated with National Health Service training programmes. This would seem to require designation of a training grade offering comparable remuneration to training posts in the National Health Service. It will also be necessary to develop a staffing structure of established posts within the Departments which facilitates the movement of trained specialists in community medicine between the Departments and the health service authorities and vice versa. Complete parity is unlikely whilst pay is determined by different bodies and terms and conditions of service differ; and the needs of the Civil Service for a relatively more hierarchical structure must be taken into consideration. However, as close a comparability as possible between grades carrying equivalent responsibility should be recognised as a deliberate objective.

SUPERANNUATION

132. As the movement of community medicine specialists between Government Departments, the different levels of the service, and the universities is an essential factor in our recommendations, we suggest that there is need for an examination to be made of the differing superannuation arrangements at present in force, to ensure wherever possible the removal of any barriers to movement created by the financial disincentive of moving from one superannuation scheme to another.

CHAPTER VII

CONCLUSIONS

133. Our remit to review the functions and training of medical administrators within the health services posed us several problems. We decided that we should concentrate on medical administration in a reorganised service, but, by doing this, we were under the disadvantage of not knowing what would be the management structure of the new regional and area authorities or whether there would be any management organisation at a district level; nor did we know

what would be the relationships between the various levels of administration. Because of this uncertainty, we have been reluctant to make firm recommendations about the detailed staffing requirements of the new authorities, to provide job descriptions, or to suggest how the chief administrative medical officer at area or region should organise the work of other community medicine specialists. Nor have we thought it proper to try to define what should in future be the relative roles and relationships between these doctors and others engaged in administration. We have been conscious also that it was not part of our remit to consider the organisation of medical care within a unified service or to spell out the role of clinicians in management, either as individuals or through medical advisory machinery.

134. In our report we have tried to indicate the essential functions which we consider doctors engaged in administration should undertake at various levels. We believe that such functions will have to be carried out whatever organisational structure is adopted, though the structure will inevitably affect how work is organised and staff deployed. However, we found it necessary to make some organisational assumptions for the district before we could define the functions of the district community physician.

135. We see a vital and continuing task for doctors working full time in health service administration. These doctors should not undertake administrative duties which can be carried out as effectively by non-medical administrators or other professional staff; on the other hand, the contribution they make to administration goes far beyond a simple liaison function between management and clinicians. Their value is primarily in the skill and knowledge they contribute as specialists in community medicine.

136. Specialists in community medicine will be needed at all levels of the service including the district, where they will be essential members of any district management teams. They will be particularly concerned with:

i assessment of need for health services;
ii planning of services to meet needs;
iii promotion of health, including health education;
iv measuring the effectiveness of health care services and promoting improvements;
v promotion of research and development into the organisation of health care services;
vi integration of health services and their co-ordination with other services, particularly the relevant services provided by local government; and
vii provision of medical advice and services to other bodies, including local government authorities responsible for environmental hygiene and the control of communicable disease.

The development of health information systems will be an essential pre-requisite to the performance of many of these functions.

137. Community medicine has its roots in public health and social medicine and has grown in more recent times to embrace hospital and other forms of medical administration. The creation of the Faculty of Community Medicine has

now provided formal recognition of the specialty. Proper training and satisfactory career patterns are vital if medical graduates of the necessary calibre are to be recruited into it. Development of satisfactory training arrangements will require a considerable collaborative effort between academic, professional and health service bodies. It will necessarily take some years to establish the training and staffing structures we advocate, and transitional arrangements will be necessary.

138. We are conscious that doctors, particularly some of those at present working in the public health services, are concerned about the uncertainty of their own future within a reorganised service. Their present employment will be disrupted when new employing authorities with wider and different management responsibilities are created. They will be called upon to undertake new tasks and, in some cases, to give up work which was hitherto their responsibility. There are many doctors in the public health services whose work lies wholly or primarily in the clinical field. Their duties lie outside our terms of reference but we wish to stress that we see a continuing need for these clinicians within the reorganised service for the foreseeable future. There is urgent need, however, to clarify how they will fit into the future organisational pattern of health care, so that they can be given assurances about their future.

139. We cannot, of course, dispel the uncertainties which individuals may have about the future. But we hope that this report will help to remove any remaining doubts about the importance of the role of doctors in the health service administration of the future. The changes to be made in 1974 will bring to an end the historic office of medical officer of health. The achievements of many who have served in this capacity over the last century gives us great confidence in the ability of those doctors at present in the public service and in hospital service administration, not only to face the problems ahead, but also to exploit the enhanced opportunities for the practice of community medicine which an administratively unified National Health Service will offer. We are confident that their contribution to the development of health services and the improvement of the health of the community can be as impressive as their predecessors.

APPENDIX A

SUMMARY OF MAIN POINTS

(Note: this summary is intended only as a guide to the main points made in the report, and does not constitute a part of it.)

CHAPTER I: INTRODUCTION

1. The Working Party's terms of reference cover only those doctors in the health services (referring also, where appropriate, to those in the central Health Departments) who are wholly or substantially concerned in medical administrative work and who do not practice clinical specialties. Such doctors are employed mainly by local authorities and regional hospital boards and in the central Health Departments. (Paragraph 3.)

2. The different spheres in which doctors in community medicine practice are sufficiently closely related to require a common basic training and experience. These doctors form a distinct specialty group. (Paragraph 4.)

3. Doctors trained in community medicine should form part of the health service administration rather than acting only in an advisory capacity to management. (Paragraphs 5 and 6.)

4. The description "specialist in community medicine" as a generic term is more appropriate than that of "medical administrator". (Paragraph 7.)

CHAPTER II: COMMUNITY MEDICINE IN A UNIFIED SERVICE

5. Community medicine specialists will have a key role to play at every level in the reorganised service since the aims of community medicine are so closely related to the objectives of a unified service. (Paragraphs 12–14.)

6. Because of their training and experience, community medicine specialists will be qualified to play a major part at all levels in assessing need for health services, measuring the effectiveness of services, establishing priorities, promoting improvements in existing services and developing new ones. They will also have important liaison functions with other bodies and will need to establish close links with the new local government authorities concerned with social, education, housing and environmental health services. (Paragraphs 12–18.)

7. The new local government authorities should obtain their medical advice from community medicine specialists in the National Health Service. (Paragraph 18.)

8. Specialists in community medicine must have the same professional status and comparable career prospects as their colleagues in clinical practice. (Paragraph 19.)

9. In the unified service there will be much more scope for the collective approach by clinicians and community medicine specialists to health problems. (Paragraphs 20–24.)

CHAPTER III: THE COMMUNITY MEDICINE SPECIALIST AT A REGIONAL LEVEL

10. There will be a need for a chief administrative medical officer at regional level, supported by a team of other administrative medical officers. (Paragraph 26.)

11. The CAMO will be a member of the group of chief officers responsible for advising the regional authority on the overall development of services, including the capital programme. He will be involved in consultations with the central Department about the setting of national objectives and concerned with the translation of these into workable policies at regional and area level. He will have executive responsibilities delegated to him by the regional authority. (Paragraph 27.)

12. Collaboration with local authorities in the planning of services will be a prime responsibility of area health authorities, but the regional CAMO will need to be involved where strategic planning issues are involved. (Paragraph 29.)

13. It is assumed that it will be a responsibility of the regional authority to control overall medical staffing establishments in the region, and this will be a particular concern of the CAMO and his staff. (Paragraph 30.)

14. The CAMO and his staff will be concerned with the co-ordination and monitoring of area health care services (paragraphs 31–33); the allocation of resources to region and area (34); building up and maintaining health information services for the region (36–42); postgraduate medical education (43–44); the provision of medical expertise in the handling of building projects (45); the promotion of research and development (46–47); and the provision of specialist advice (48–49).

15. While no blueprint is laid down for the allocation of responsibilities of the CAMO's medical staff, the Working Party would like to see responsibilities allocated in such a way as to ensure a comprehensive approach, and a functional division of duties is suggested. (Paragraphs 50–51.)

16. The need for a medical expert in information services in each region is stressed. (Paragraph 52.)

CHAPTER IV: RESPONSIBILITIES OF COMMUNITY MEDICINE SPECIALISTS IN AREA HEALTH AUTHORITIES

17. Community medicine specialists will have a special role to play in securing the most effective use of the area health authority's considerable resources. (Paragraph 54.)

18. The functions of community medicine specialists will be the same in all areas but there will necessarily be differences in their numbers and deployment between areas. Each district sized population should be the special concern of a specialist in community medicine. (Paragraph 55.)

19. Community medicine specialists in areas will be concerned with the provision of health information (paragraphs 57–59); planning (60–61); management of health services (62–76); the provision of advice and assistance to local authority departments—particularly social services and education—and to

voluntary and other bodies on planning and management (77–80); and the provision of medical services required by local government authorities with responsibilities for environmental hygiene and communicable disease control (81–84).

20. It will be part of the CAMO's responsibilities to see that the expert advice of clinicians is sought on all appropriate matters; and that the area authority's professional advisory committees have adequate professional services and information to do their job effectively. (Paragraph 85.)

21. Each area will need to have a chief administrative medical officer, and it is essential that he should be a chief officer to the area authority with direct access to it. It is not essential that he should be the chief executive officer to the authority, although if such a post is created he would be a strong contender for it. (Paragraph 87.)

22. In his relations with doctors and others outside the area headquarters, there is much merit in the concept of the CAMO acting as a staff officer of the authority, which would enable him to speak as the agent of the authority. (Paragraph 87.)

23. It is suggested that minimum staffing requirements for an area comprising three districts, each with 200,000 population, would be one CAMO and at least 3 other community medicine specialists as well as one specialist engaged wholly or substantially at district level in each district. (Paragraph 88.)

24. At area level, work might be divided functionally into information services; medical staffing, training, and personnel work; and specialist sectors of health services. (Paragraph 88.)

25. Doctors such as "community paediatricians" should not be confused with community medicine specialists, whose expertise lies outside the clinical field. (Paragraph 90.)

26. The CAMO should contribute a section to any regular report made by his authority, and his contribution should be regarded as his own personal report. (Paragraph 91.)

CHAPTER V: THE STATUS AND FUNCTIONS OF THE DISTRICT COMMUNITY PHYSICIAN

27. There is a substantial job to be done by a "generalist" community physician for a district-sized population. The post would be a senior appointment of similar status to that of consultant. (Paragraph 92.)

28. An important part of the district community physician's role will be to provide a service to his clinical colleagues to enable them to fulfil their responsibilities more effectively. (Paragraph 93.)

29. The community physician will have an invaluable part to play in ensuring that the district medical advisory machinery works effectively. (Paragraph 94.)

30. The community physician must be a member of any district management team. He may undertake particular executive tasks within the district on the authority of the management team. (Paragraph 95.)

31. No member of the district management team should have directing authority over the others, but it will be necessary for one person to undertake co-ordinating duties. (Paragraph 95.)

32. The district management team might be responsible collectively to the area health authority. In respect of the work he undertakes as a member of the district management team, the community physician would be responsible to the area authority. He would be responsible direct to the area CAMO for services organised on an area rather than a district basis; where he was the adviser of the local government district authority on environmental hygiene and communicable disease control he would be accountable to it in respect of these matters. (Paragraph 96.)

33. A summary is made of the main elements of the district community physician's work, in his capacities as specialist in community medicine, member of the district management team, and member of the group of community medicine specialists employed by the area health authority. (Paragraph 97.)

CHAPTER VI: TRAINING AND CAREER STRUCTURE

34. There are two requirements which must be met in order to recruit specialists in community medicine in the numbers needed: first, a proper training programme must be established, and second, this training programme must lead to an attractive career structure (Paragraph 100.)

35. Any arrangement for training should be regarded as experimental and reviewed in the light of experience. (Paragraph 104.)

36. Before beginning specialised postgraduate training, a doctor should have a minimum of two years' post-registration clinical experience, some of it preferably gained outside hospital. (Paragraph 105.)

37. It is envisaged that specialised postgraduate training will be for a period comparable in length with that of most clinical specialties. A major element will be in-service experience in suitable training posts, but opportunities for formal academic study are needed as well. (Paragraph 107.)

38. There might be advantage in developing arrangements whereby formal academic study is spread over a number of separate courses, providing in all the equivalent of about one academic year of full-time study, but spread over, say, two calendar years. Such courses would be based on academic departments. Between courses doctors would be gaining experience in training posts. (Paragraph 108.)

39. The detailed content of basic training is not prescribed, but six subjects are listed in which the doctor in training should undertake formal full-time study early in his specialised training. (Paragraph 109.)

40. Further specialised training in particular subjects should be available to doctors who wish to make a career in a particular specialised field, e.g. medical information science. (Paragraph 111.)

41. After basic training, doctors should have the opportunity to attend multiprofessional courses in health services management. (Paragraph 111.)

42. As far as practicable, provision should be made for movement between health service and academic posts during training. (Paragraph 112.)

43. One way to provide specialised training would be by the participation of a number of teaching centres, each supplying expertise in different fields. Another way is by the more traditional approach of a single university centre providing a comprehensive academic course. (Paragraph 113.)

44. The development of suitable in-service training posts will be a major joint responsibility of the new health service authorities and the academic and professional bodies concerned. (Paragraph 115.)

45. It should be possible for mature entrants to receive training in particular subjects without undertaking a fully comprehensive training programme. (Paragraph 116.)

46. It will be necessary for community medicine specialists to have opportunities for continuing education. (Paragraph 117.)

47. It is essential that the universities and the Faculty of Community Medicine work closely together in the development of training for community medicine. (Paragraph 118.)

48. A national representative body should be convened under the aegis of the Council for Postgraduate Medical Education to oversee the development of training. (Paragraph 119.)

49. There is a need to give undergraduate medical students a thorough grounding in community medicine. The problem of the lack of progress in teaching community medicine at undergraduate level urgently requires action. (Paragraph 122.)

50. At central, regional and area levels in the reorganised service, it will be necesary to maintain hierarchical staffing structures. (Paragraph 124.)

51. There should be, in addition to the chief officer grade, at least one other service grade, which would be the main career grade for doctors successfully completing specialist training in community medicine. This grade would be comparable in status to that of clinical consultant and would include district community physician posts. (Paragraph 124.)

52. Appointments procedures for community medicine specialists should, as far as possible, be similar to those for consultants. (Paragraph 125.)

53. The basic remuneration of doctors in the career grade should equate with that of consultants. The restriction of distinction awards to doctors in clinical specialities is anomalous, and will become even more so when community medicine achieves its full potential. (Paragraph 126.)

54. It is hoped that more university teachers in social medicine will obtain honorary contracts with health service authorities, and that specialists in community medicine will be able to obtain honorary university teaching appointments. Co-operation between universities and service authorities will be an essential ingredient in the development of the specialty of community medicine. (Paragraph 127.)

55. Arrangements are suggested whereby the salaries of doctors beginning training in community medicine after holding posts in a higher grade in another speciality might be protected. (Paragraph 129.)

56. At least during the transitional period, there will be need for a further service grade in addition to the specialist grade. (Paragraph 130.)

57. There is need to establish within the Health Departments posts formally designated for training and integrated with NHS training programmes. It is also necessary to establish in the Health Departments a staffing structure which facilitates the movement of community medicine specialists between the Departments and health service authorities. (Paragraph 131.)

58. There is a need for an examination of existing superannuation arrangements to ensure wherever possible the removal of any disincentives to movement between different authorities at all levels. (Paragraph 132.)

APPENDIX B

MEDICAL STAFF IN ADMINISTRATIVE POSTS IN THE HEALTH SERVICES AND IN THE CENTRAL HEALTH DEPARTMENTS IN ENGLAND AND WALES

1. **Regional Hospital Boards and Welsh Hospital Board**	*Staff in post at 30 September, 1971.*
Senior administrative medical officers	15
Principal assistant senior medical officers*	54
Assistant senior medical officers	51
Medical officers	8
TOTAL	128

2. **Local Authorities**†	*Staff in post at 1 July 1971*
Medical officers of health of local health authorities, authorities with delegated health powers, and district authorities (not also holding county appointments)	186
Deputy medical officers of health of local health authorities, and authorities with delegated powers	166
Medical officers holding "mixed" appointments with local health authorities and district authorities‡	336
Medical officers of local health authorities in senior posts in the upper salary range (not also holding district appointments)‡	459
TOTAL	1147

* In each region one PASMO is designated for deputising duties and paid an allowance above his basic salary.

† These figures are based on a special enquiry made by the British Medical Association and published here with their permission. Three authorities did not reply and a small number of those medical officers of health of districts who do not hold "mixed" appointments may also have been missed because of the way in which the survey was conducted.

‡ The total number of doctors holding senior posts in the upper salary range was 459. The survey conducted by Warren & Cooper published in "The Medical Officer" of 13 October, 1967 suggested that about half the medical officers engaged in senior posts were engaged mainly in administrative as distinct from clinical duties.

Analysis of Doctors Holding Mixed Appointments

		District Authority Appointments				
		MoH	DMoH	Other	Not Known	Total
LHA APPOINTMENTS	MO in Senior Post	173	11	–	1	185
	MO in Department	91	21	2	–	114
	Others	20	11	1	5	37
	Total	284	43	3	6	336

3. **Headquarters Medical Staff of the Department of Health and Social Security (§) and the Welsh Office**

Staff in post at 1 February 1972

DHSS	
Chief medical officer	1
Deputy chief medical officer	3
Senior principal medical officer	5
Principal medical officer	21
Senior medical officer	53
Medical officer	36
Welsh Office	
Chief medical officer	1
Senior medical officer	2
Medical officer	4

APPENDIX C

THE WORK OF MEDICAL ADMINISTRATORS IN THE PRESENT HEALTH SERVICES AND IN THE CENTRAL HEALTH DEPARTMENTS IN ENGLAND AND WALES

1. Medical administrators are currently employed by regional hospital boards (including the Welsh Hospital Board) and local authorities and in the central Health Departments; in addition, in a number of mental subnormality and other long stay hospitals, doctors, commonly designated as medical superintendents, combine clinical and administrative roles.

The Work of Administrative Medical Staff of Regional Hospital Boards

2. The role of regional boards was described* at the outset of the service in the following terms.

i To review and organise to the best advantage all the existing resources in the hospital and specialist field.

ii To assess the need for and best placements of new resources and extensions.

iii To administer, largely through a system of local management committees, the whole re-organised services.

§ Excluding the Chief Medical Advisor (Social Security) and his staff.

* Ministry of Health circular RHB (47) 1.

iv To secure, by the above processes and by arrangements (where necessary with other boards and with separate teaching hospitals) that a proper and sufficient service of all kinds is available to all persons in their area.

A later memorandum (†) described the position assigned to boards as "the planning, distribution of resources, and general supervision and guidance of the service".

3. The senior administrative medical officer is a chief officer of the regional hospital board and with other chief officers is responsible to the board for the administration and development of the hospital services in the charge of the board. In his work he co-operates with other administrative and professional colleagues to undertake the following functions:—

i Preparation of advice and objectives for his authority and its committees in order that they can determine or approve policy on the overall development of the regional service. In this work the medical administrator has to obtain and assess relevant medical information from within and outside the region.

ii Assisting his authority to take appropriate decisions for the implementation of policies and the achievement of objectives, and participating in subsequent action (for example, in planning teams for capital building projects).

iii Discussion with the Health Departments over major matters such as the capital and revenue allocations, and, where necessary, over the regional interpretation and implementation of national policies.

iv Ensuring there is a sound medical and paramedical manpower, education and training policy in the region and that the requisite conditions and facilities for this are provided. In this respect he must act in close liaison with educational and professional bodies, in particular the postgraduate dean of the university in the region.

v Providing a personal link between individual clinicians, medical committees, and the regional authority with whom they are in contract.

4. The organisation of medical administrative work under the SAMO has not followed exactly the same pattern in each region, but it has become usual for those in the PASMO grade to undertake specialised functional duties covering the region as a whole. At ASMO level the emphasis has been more frequently on sub-regional liaison work—the region being split into a small number of areas for which an ASMO has a general responsibility for liaison—and covering those matters which are not handled on a functional basis for the region as a whole.

5. The administrative medical staff of regional boards do not stand in a hierarchical relationship with clinicians, and in the implementation of board policies affecting the work of clinicians they work by seeking their consent and co-operation.

6. Regional boards do not have a designated chief executive officer and the SAMO is one of a group of senior officers responsible directly to the board.

† Ministry of Health circular RHB (47) 11.

Medical Administration at Hospital Level

7. At a hospital level there were, prior to the inception of the National Health Service, two distinct and separate traditions. In the hospitals administered by the local authorities, management was in the hands of medical superintendents who normally combined administrative and clinical duties; the role of the non-medical administrator was clearly subordinate though growing in importance. In the voluntary hospitals, on the other hand, responsibility for the medical management of the hospital was vested in the medical committee which was advisory to the governors of the hospital. There was, with few exceptions (for example, Guy's Hospital), no medical counterpart to the clerk to the board on the administrative side. This difference in management no doubt reflected the dominant position in the voluntary hospitals of the part-time medical specialists.

8. After 1948, although provision was made for the continuation of medical superintendents in the hospitals providing long term and custodial care for the chronic sick (sanatoria and mental hospitals), the usual pattern in the general hospitals was similar to that in the voluntary hospitals. Since then, the tendency has been for the number of medical superintendents in post to decline, and the view of the majority of hospital doctors and administrators in this country has been that the concept of the single medical administrator in charge of the hospital or hospital group is out-moded.

9. Current thinking on the place of doctors in management of hospitals locally is set out in the first report of the Working Party on the Organisation of Medical Work in Hospitals (the Cogwheel report).* The concept (it was not a detailed blueprint) set out in the report was that within the hospital group there was a need for a representative group of clinicians to undertake a continuous review of hospital activity, to take an active part in the co-ordination and planning of services, and to provide effective liaison with the community services outside the hospital. The working party did not think the then existing medical advisory machinery met modern requirements, and recommended the organisation of medical staff in the hospital group into a number of divisions, comprising broadly related specialties, and a small medical executive committee headed by a chairman who would be the chief medical spokesman for the hospital or hospital group. The function of each division was to appraise the services it provided, deploy clinical resources effectively, and deal with problems of management within the clinical field. The function of the executive committee was to receive divisional reports, consider major medical policy and planning, and co-ordinate hospital clinical activities without controlling or limiting the clinical freedom of individuals. The report saw the organisation of clinical functions as an activity distinct from the general management of hospitals, but stated that each affected the other and that decisions could not be made in either field without regard to the other: "the situation will not be solved by providing an administration predominantly medical in character, assuming incorrectly that clinicians can only communicate on such issues with administrators who are medically qualified. A medical man engaged in general management would be acting in an entirely non-medical capacity" (paragraph 35). The Cogwheel recommendations have so far been adopted, with local variations, by more than half of the general hospital groups in England and Wales.

* First Report of the Joint Working Party on the Organisation of Medical Work in Hospitals: HMSO, 1967.

The Work of the Medical Officer of Health

10. The historic origins of the medical officer of health are in the field of prevention, and he still has a statutory duty to inform himself about all matters affecting the health of his area, and to ascertain, report and advise upon all conditions which will affect the health of the community. The emphasis in the work has, however, adapted itself to changing circumstances. The major activity in the latter part of the 19th century and in the early 20th century lay in the control of the spread of communicable disease and the improvement of environmental health, including such matters as water supplies, refuse and sewage disposal, and housing. In those days the medical officer of health had to undertake wide responsibilities in relation to environmental health, acting in areas where skills other than purely medical ones were required of him because there was no one else competent to shoulder the responsibility. The present century has seen the development of scientific and technical disciplines, and of experts in these disciplines such as public health inspectors, water engineers and experts in planning and housing. This development has enabled the medical officer of health to reduce his administrative responsibilities in these fields to matters that are more directly medical, and control of environmental health has now become the responsibility of a team of experts whose success depends upon a co-ordination of diverse skills and knowledge. In the medical aspects of environmental health he now also relies on the assistance of other medical specialists. Thus he is no longer so actively concerned with practical bacteriology, and consults with his colleagues in the Public Health Laboratory Service on specific epidemiological matters and on the interpretation of bacteriological findings; and in the control of infectious disease he can call also on the expertise of clinical specialists. But it remains the responsibility of the medical officer of health to recognise potential hazards within the community for which he is responsible and to obtain the requisite specialist help.

11. The medical officer of health has always been deeply concerned in the primary prevention of disease, and his interest has gradually extended from such matters as environmental hygiene, clean food, and immunisation, to tackling modern epidemics of preventable conditions, such as those caused by cigarette smoking. All members of the health professions have been increasingly involved in trying to deal with these contemporary problems, but much of the initiative for primary prevention has remained in the hands of the medical officer of health and his multi-disciplinary team.

12. From the beginning of the present century, the medical officer of health has also concerned himself with secondary prevention—with the routine examination of particularly vulnerable sections of the population, with the development of screening tests, and the arrangement for follow-up of those identified as in need of specialist care and treatment. This concern has its origins in the development of the School Health Service following the Education (Miscellaneous Provisions) Act, 1907, and of the maternity and pre-school child health services, the statutory foundations of which were laid by the Maternity and Child Welfare Act, 1918.

13. The personal health services provided under the direction of the medical officer of health have subsequently broadened and expanded considerably, often to fill gaps in provision left uncovered by the hospital and family doctor services, or to develop new approaches to health care, particularly in those areas which

are sometimes described as the tertiary stage of preventive health work—the prevention of relapse and recurrence of disability through the provision of supporting health services outside the hospital, and commonly in association with general practitioners. These personal health services are provided only by the major authorities (county councils, county boroughs, and London boroughs) and by a small number of district authorities with delegated health functions. However, nearly all medical officers of health of non-county boroughs and urban and rural districts have combined appointments with major authorities, so that they have some involvement in the personal health services provided by the latter.

14. Medical officers of health have also increasingly concerned themselves with the social factors underlying health problems, but, as in the environmental health field, their role has changed as new professions particularly concerned with these matters have emerged, and, following the Social Services Act, 1970, the responsibility for some of the services formerly under the charge of the medical officer of health passed to statutory social service departments within local government. Nevertheless, responsibility for advising these departments on medical matters is still an important responsibility of the medical officer of health.

15. Within the health services provided by local health authorities, the tendency in recent years has been for individual professions to seek internal self-management, so that although the medical officer of health has remained the head of the health department, his administrative role as a manager of health service personnel generally has changed. He does, however, remain formally in a different position from the senior administrative medical officer of a regional hospital board in that he is directly responsible for the work of a wide range of medical, nursing and other professional staff who are, in organisational terms, subordinate to him.

16. The role of the medical officer of health over the last century has, therefore, been an evolving one. His managerial role in relation to the non-medical staff has declined, but not his importance as medical adviser to the extensive range of agencies now responsible for the well-being of the community and the protection of the environment: and as chief officer of the health department and principal medical officer to the education authority he has responsibility for the planning and control of considerable resources in terms of skilled manpower and money, and has become increasingly involved in management functions relating to the assessment of objectives, the evaluation of services, and the determination of priorities.

17. This has led to a growing involvement in the co-ordination of local authority health services with the other statutory and voluntary ones. This, in turn, has been facilitated by the flexibility of policy and finance inherent in the local authority branch of the National Health Service, and is well exemplified by schemes for the attachment of nursing staff to general practices, and by joint hospital and domiciliary approaches to after-care.

18. The current (and recent) responsibilities of medical officers of health may be summarised as follows:—

Group A This covers the traditional public health services which, under the proposed re-organisation of health service and local

government functions, would remain with local government (except that measures for the control of communicable disease by specific prophylaxis and treatment would be the responsibility of the area health authorities). These responsibilities are currently carried out by medical officers of health of county, London and non-county boroughs, and of urban and rural districts, but not of counties.

The control of communicable diseases
Food safety and hygiene
Port health
Public health aspects of environmental services—e.g. in relation to planning, housing, clean air
Diseases of animals in so far as they affect human health
Enforcement responsibilities relating to environmental conditions at work places.

Group B This covers the services, currently provided by county councils, county boroughs, London boroughs and authorities exercising delegated health and welfare functions, which will become the responsibility of the new area health authorities.

Ambulance services
Epidemiological work (general surveillance of the health of the community)
Health centres
Family planning
Health visiting
Home nursing and midwifery
Maternity and child health care
Prevention of illness, care and after-care, through medical, nursing and allied services (including chiropody, health education* and screening)
Residential accommodation for those needing continuing medical supervision outside hospital but unable to live in the community
Vaccination and immunisation
School health service.†

Group C This covers those services provided by local government authorities which were formerly the concern either wholly or partly of the medical officer of health, but which, under the Local Authority Social Services Act, 1970, became the responsibility of the new local authority social service departments.

Family case work and social work with the sick and the mentally disordered
Day centres, clubs, adult training centres and workshops for the mentally disordered
The day-care of children under 5, day nurseries and child-minding

* The Government's proposals appear to envisage that both the new area health authorities and the new local government authorities would have powers in relation to health education.

† At the time of writing, no decision had been reached as to whether the school health service should become the responsibility of the new area health authorities or remain the responsibility of local government.

The care of unsupported mothers, including residential care
Residential accommodation for those who cannot live at home but who do not need continuing medical supervision
Home helps.

Group D In addition to their responsibilities in relation to the statutory services listed above, medical officers of health undertake a wide range of complementary functions. Important amongst these are:—

i A co-ordinating and supportive role in relation to family practice and the hospital services (through, for example, implementation of attachment schemes, liaison committees, planned early discharge and after-care schemes).
ii Co-ordinating and advisory services to voluntary agencies, and medical advisory services to local government departments and public bodies.

Work of Medical Staff in the Central Health Departments (Department of Health and Social Security and the Welsh Office)

19. The medical staff of the two Departments participate in the formulation of policy and are jointly responsible with their administrative colleagues for policies recommended to Ministers. They are also responsible for the provision of medical information and advice routinely required within their Departments. The nature of this advice and information ranges from that of a very general medical character to the highly specialised. In some fields of high specialisation, individual members of the medical staff are of national or international standing in their subject. In less specialised fields doctors on the staff develop expertise in subjects allocated to them. They provide information and advice related to their subjects and interpret trends in their development. It is part of their duties to maintain close relations with appropriate individuals and specialist organisations outside their Department, both nationally and internationally, and to obtain additional assistance and advice from these sources when necessary. The medical staff of the Department of Health also advise other central Government Departments (for example, the Department of the Environment, the Ministry of Agriculture, Fisheries and Food and the Home Office) on matters requiring medical expertise.

20. Much of the medical administrative work within the Health Departments is in the day-to-day work of dealing with the statutory authorities running the health services at regional and local level. In addition, medical administrators are responsible for maintaining a general liaison between the Health Departments and administrative medical staff in the hospital and local authority services and doctors in general practice.

21. A further important area of work undertaken by doctors in the central Departments is in relation to the medical profession and organisations within the profession. They play a leading part in discussions with the official negotiating bodies of the profession on changes in policy, practice and organisation of the NHS, and in representing the Departments at meetings with other professional bodies, nationally and internationally.

APPENDIX D

SERVICES WHICH WILL BECOME THE RESPONSIBILITY OF AREA HEALTH AUTHORITIES*

1. The broad range of services for which the area health authority will be responsible is as follows:—

i The hospital and specialist services (at present administered by hospital management committees as agents of the regional hospital boards, and boards of governors).

ii The community health services listed below which are at present the responsibility of local health authorities:

ambulance services;
general surveillance of the health of the community;
family planning;
health centres;
health visiting;
home nursing and midwifery;
maternity and child health care;
prevention of illness, care and after care, through medical, nursing and allied services (including chiropody, health education—other than its place in the school curriculum—and screening);
residential accommodation for those needing continuing medical supervision and not ready to live in the community; vaccination and immunisation.

iii The family practitioner services (at present administered by executive councils).

APPENDIX E

THE URGENT NEED FOR THE SHORT TERM INTRODUCTION OF TRAINING COURSES IN MEDICAL ADMINISTRATION: AN INTERIM REPORT TO THE SECRETARY OF STATE FOR SOCIAL SERVICES (OCTOBER 1970)

Background

1. The remit of the working party is:

"To review the functions of medical administrators in the health services and to make recommendations regarding the provision required for their training".

2. We have invited written evidence from organisations and individuals and until this has been considered and we have built up a picture of the functions

* As described in paragraph 36 of the Second Green Paper (The Future Structure of the National Health Service, HMSO, 1970).

of medical administrators in the future, we shall not be able to make comprehensive recommendations about the total training requirements of these staff. A further difficulty in assessing training needs at present is that we do not know in any detail what the future structure of any re-organised health service may be. However, we have already reached the firm conclusion that whatever may be the future pattern of health service administration and the role of the medical administrator within it, there is an urgent need to provide a retraining programme for medical administrators now in post. When the health services are re-organised on a unified basis, medical administrators whose main experience has been in public health, the regional boards, central government or the universities must come together to form new corps and in effect a new specialty in medicine. Straight away their work will be altered, needing different attitudes and the use of new methods as well as fuller use of the established methods of medical administration. Their responsibility will be towards a defined population and its health care. They will be aiming to unite existing facilities and resources into a comprehensive service, and to co-ordinate this with other social services and wider policy. A more objective and quantitative approach to the changing health-needs of populations and to the organisation of health care in its various phases is now generally recognised as essential. Many of the necessary "analytic and investigative skills" (to quote the Todd Report) have been developed in recent years, since most of today's medical administrators completed their formal training. Even if the NHS were not to be re-organised, the training programme we propose would still be essential in helping medical administrators to see how the separate parts of the health service can be co-ordinated and made more efficient.

3. At present there are only a handful of medical administrators in a position to know from direct experience the problems of providing total health care for a whole community. We are aware that much has been done to bridge the gap between the three branches of the service, but if the resources of our increasingly complex and costly services are to be used to maximum effect, all those concerned with health service administration must be aware of the need for an integrative approach, and medical and other administrators must have the necessary knowledge and skills to achieve it.

4. Further, we are aware that in the light of the Secretary of State's decision to unify the administrative structure of the health service, the need to have a retraining programme for medical administrators has become urgent, and that a considerable time will be necessary to set this up. We would emphasise that an early decision to introduce such a programme would also do much to improve the morale of those at present engaged in medical administration which has been affected by the uncertainty about their future careers. In the case of the largest group—those in the public health services—this uncertainty has been compounded by the knowledge that the social services they administer will cease to be their responsibility shortly as a result of the Social Services Act. They see a substantial part of their work disappearing, with little indication of any new role for them. The introduction of a retraining programme would provide a very necessary reassurance.

5. For these reasons we think it necessary to submit proposals for such a programme in advance of our final report. We wish consideration to be given to our proposals as a matter of urgency.

Proposals for training programme

6. We understand that there are roughly 120 full time medical administrators employed by RHBs, about 650 doctors primarily engaged in medical administration employed by local authorities and about 100 similarly employed by central departments. We assume that there is no purpose in retraining those now over the age of 60, but allowing for some waste and replacement of retrained doctors, we see a need to provide retraining for around 800 doctors, and we think this should be achieved over as short a period as possible as a specially organised programme. We think the target should be to complete the programme over five years.

7. We think it is highly desirable that doctors from regional boards, local authorities and central government should attend the same courses, as this itself will help to broaden mutual understanding, particularly as we see the courses as being often participatory, involving group discussions and simulated work situations. Medical administrators will necessarily be closely involved in their work with health service staff in other disciplines and just as their work will require close inter-professional co-operation so we believe that their retraining should be in part multi-disciplinary, including for example nursing staff, other health service administrators, and directors of social services or their staff.

8. It would be desirable to concentrate the organisation and management of courses at a few centres in order that the scarce teaching resources in this field are used to best advantage and a stronger cadre of teachers built up. The only firm and detailed proposals for retraining we know of so far have come from the London School of Hygiene and Tropical Medicine. The School envisages the creation of an Extension Training Centre providing specialised courses in a variety of relevant subjects.

Content and length of courses

9. As noted above, the primary purpose of the courses will be to develop an integrative approach to the provision of health services. Much of the value of a unified service will be lost if medical administrators are unable to appreciate and exploit the new possibilities.

10. We do not wish to define rigidly what should be the content of courses or the degree of emphasis to be given to different subjects. We think a flexible approach will be necessary, both to take account of the varying experience of medical administrators and because the training centres themselves may well have to build up expertise in particular areas.

11. We think that it should be practicable for medical administrators to spend something in the order of 6–8 weeks in training. This might be achieved by attendance at two separate courses rather than one.

12. The training we recommend will have two main aims. First, to provide medical administrators with an understanding of the working of the health and related social services other than those within which they are at present engaged, and secondly to provide them with a basic appreciation of relevant developments within the specialty of community medicine and in administration and management generally.

13. We think there will be some elements within the courses which will be of value to all who attend, whatever their previous experience. These include the place of epidemiology in medical administration, social administration, management theory and methods, statistics, medical sociology and the economics of health care. Special attention would need to be given to the study of staff relations in the health service. But a large part of the courses ought to be given over to training in a range of optional subjects from which those attending the course could choose depending on their previous experience and potential needs. These subjects might include the organisation, planning and management of hospital services, including such recent developments as the "Cogwheel" system of management, similar teaching in relation to health and social services outside the hospitals, bio-statistics, medical information systems, the application of computers and operational research methods in the health field. The above is not intended to be comprehensive and we would expect that the content of courses would be adapted over time in the light of experience. But we are anxious to avoid covering so much ground in any one course that teaching becomes over-generalised and ineffective.

Overall management of training

14. We do not think that the training programme we propose will be effective unless its progress is supervised. Primarily, the tasks will be to ensure that authorities release staff for training to ensure that each doctor gets the requisite training to fill the gaps in his knowledge, and to exercise a general supervision of the content and quality of courses. We envisage that initially these responsibilities would be in the hands of the Department which would be in collaboration with health service authorities, the universities and other appropriate bodies.

Finance

15. We are aware that the general policy of DHSS has been that employing authorities should take financial responsibility for training their staff, and that local authorities act as autonomous bodies as regards training (though central finance and organisation is now available through the Local Government Training Board). We see the force of the principle that employing authorities should accept their responsibilities for training. However, we think that there are special circumstances arguing in favour of the provision of central financial support for retraining of medical administrators. These are:

(a) The special urgency of the need—which in turn means that the national programme should not be jeopardised by the unwillingness of individual authorities to find the money. Now that a decision has been taken to re-organise the health services, outside local government, local authorities may be unwilling to spend their limited resources on the training of staff who will in future not be employed by them.

(b) The need to ensure equal opportunities for training for all medical administrators—medical administrators may feel that those able to obtain retraining will have an advantage in applying for jobs in the re-organised service.

(c) Some central finance by way of grants may be necessary in order to establish centres of training, whatever may be the source of continuing income.

16. We would emphasise that our proposal that this retraining scheme should be centrally financed is made without any implications for any proposals we may make in our final report about the financing of other forms of training (e.g. vocational training) for medical administrators.

Teaching staff

17. We would hope that the retraining programme proposed would be able to draw for teaching purposes on doctors already engaged in medical administration as well as involving full-time academic teachers in the discipline involved (not necessarily medically qualified). We are sure however that additional staff will be necessary and that to attract them first-class posts need to be offered.

APPENDIX F

LIST OF THOSE PROVIDING WRITTEN AND ORAL EVIDENCE

(Note: the designations of individuals and organisations listed below were those applicable at the time evidence was submitted.)

Written Evidence

Written evidence was received from the following individuals and organisations:

Dr. J. H. Baron	Chairman, Tottenham Group Medical Advisory Committee
Mr. D. E. Bolt	Consultant Surgeon, West Middlesex Hospital
Dr. N. F. Coghill	Consultant Physician, West Middlesex Hospital
Dr. J. S. Stewart	Consultant Physician, West Middlesex Hospital
Dr. P. W. Briggs	Assistant Senior Medical Officer, South West Metropolitan Regional Hospital Board
Dr. J. Denham	Medical Director, St. Clement's Hospital, London
Dr. A. J. Essex-Cater	County Medical Officer, Monmouthshire County Council
Dr. W. A. S. Falla	Medical Superintendent, St. John's Hospital, Lincoln
Dr. H. P. Ferrer	Lecturer, University of Manchester
Dr. F. N. Garratt	Medical Officer of Health, Wolverhampton County Borough
Dr. H. Gordon	Deputy Medical Officer of Health, London Borough of Wandsworth
Dr. I. Gordon	Medical Officer of Health, London Borough of Redbridge
Mr. M. C. Hardie	Director, The King's Fund Hospital Centre

Mr. L. Hunt	Group Secretary, Clwyd and Deeside Hospital Management Committee
Dr. H. Jacobs	Senior Hospital Medical Officer, Severalls Hospital, Colchester
Dr. I. M. Librach	Medical Officer in Charge, Chadwell Heath Hospital, Romford
Dr. A. McGregor	Medical Officer of Health, City of Southampton
Dr. D. Macmillan	Director, Nuffield Centre for Health Service Studies, University of Leeds
Dr. B. Mair	Chest Physician, St. Albans City Hospital
Dr. J. W. Paulley	Consultant Physician, Ipswich Hospital
Professor J. Pemberton	Department of Social and Preventive Medicine, Queen's University, Belfast
Mr. A. F. Rushforth	Consultant Orthopaedic Surgeon, St. Albans City Hospital
Professor A. Smith Dr. D. H. Vaughan	Department of Social and Preventive Medicine, University of Manchester
Dr. C. S. Smith	Principal Medical Officer, West Riding County Council
Dr. M. D. Warren	Reader in Public Health, London School of Hygiene and Tropical Medicine

Administrative Medical Staff, South West Metropolitan Regional Hospital Board
Association of Health Administrative Officers
Association of Hospital Management Committees
Association of Municipal Corporations
Association of Public Health Inspectors: Guild of Public Health Inspectors
Association of Sea and Air Port Health Authorities
British Medical Association
British Paediatric Association
County Councils Association
Department of Clinical Epidemiology & Social Medicine, St. Thomas' Hospital Medical School
Department of Preventive Medicine & Public Health, University of Leeds
District Medical Officers of Health, Surrey
General Medical Council
Health Visitors' Association
Institute of Health Service Administrators
Institute of Local Government Administrators
Little Plumstead Hospital Group Medical Staff Committee
London School of Hygiene & Tropical Medicine
Medical Administrators Staff Association—Western Regional Hospital Board, Scotland
Medical Advisory Committee, Herrison (Dorset) Group Hospital Management Committee
Medical Advisory Committee, Norwich, Lowestoft & Great Yarmouth Hospital Management Committee

Medical Officers of Health, County Boroughs of West Bromwich, Warley, Wolverhampton, Dudley & Walsall (Drs. H. O. M. Bryant, R. J. Dodds, F. N. Garratt, G. M. Reynolds, J. C. Talbot)

Medical Officers of Health, West Riding

(Dr. S. K. Appleton
Dr. D. C. Armstrong
Dr. J. Battersby
Dr. A. T. Burn
Dr. J. T. Clow
Dr. D. J. Cusiter
Dr. W. D. Dolton
Dr. W. M. Douglas
Dr. J. F. Fraser
Dr. N. E. Gordon
Dr. N. V. Hepple
Dr. G. Higgins
Dr. M. Hunter
Dr. G. Ireland
Dr. V. P. McDonagh
Dr. C. G. Oddy
Dr. P. M. Sammon
Dr. R. Stalker
Dr. J. S. Waters)

Medical Officers of Health, Wiltshire
Medical Superintendents' Society
Medical Women's Federation
National Association of Hospital Management Committee Group Secretaries
National Association of Hospital Management Committee Group Secretaries (Welsh Branch)
Oxford Regional Hospital Board's Policy Development Committee
Public Health Laboratory Service Board
Public Health Medical Officers—Midlands
(Drs. G. Dison, C. E. Jamison, P. E. V. McFarland, E. L. M. Millar, G. M. Reynolds, M. A. Shields, J. C. Talbot)
Public Health Medical Officers—Oxford Region
Royal College of Nursing
Royal College of Obstetricians and Gynaecologists
Royal College of Pathologists
Royal College of Physicians
Royal Medico-Psychological Association
Scottish Association of Medical Administrators
Secretaries of Regional Hospital Boards (England and Wales)
Senior Administrative Medical Officers (England and Wales)
Society for Social Medicine
Society of Clinical Psychiatrists
Society of Medical Officers of Health
Society of Medical Officers of Health (Scottish Branch)
Teaching Hospitals Association
Urban District Councils Association

Oral Evidence

Oral evidence was heard from the following:

British Medical Association	(represented by Dr. R. Gibson, Dr. C. D. L. Lycett, Dr. J. C. Cameron, Dr. R. M. Mayon-White, Dr. I. M. Brown, Dr. Derek Stevenson, Dr. E. Grey-Turner, Dr. Wyn Cottell, Dr. I. Field and Miss S. R. Donovan)
Dr. J. H. F. Brotherston	Chief Medical Officer, Scottish Home and Health Department
Sir George Godber	Chief Medical Officer, Department of Health and Social Security

Professor W. W. Holland	Department of Clinical Epidemiology and Social Medicine, St. Thomas' Hospital, London
Mr. B. A. McSwiney	Clerk to the Boards of Governors, St. Thomas' Hospital, London
Institute of Health Service Administrators	(represented by Mr. S. G. Hill, Mr. R. Moore, Mr. W. M. Naylor and Mr. J. F. Milne)
Dr. A. McGregor	Medical Officer of Health, Southampton
National Staff Committee and National Nursing Staff Committee	(represented by Dame Isabel Graham Bryce, Miss I. M. James and Mr. A. J. Bennett)
The Lord Rosenheim	President of the Royal College of Physicians of London
Senior Adminstrative Medical Officers (England and Wales)	(represented by Dr. F. J. Fowler and Dr. A. J. Lane)
Society of Medical Officers of Health	(represented by Dr. W. G. Harding, Dr. D. E. Cullington, Professor R. C. M. Pearson and Dr. J. B. Meredith Davies)
Society for Social Medicine	(represented by Professor Alwyn Smith and Professor M. D. Warren)

Printed in England for Her Majesty's Stationery Office
by McCorquodale Printers Ltd., London.
HM5485 Dd502415 K64 5/72 McC3309

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